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THE APPENDIX VERMIFORMIS; ITS FUNCTIONS, AND PATHOLOGICAL CHANGES AND THEIR TREATMENT.¹

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Preliminary to a consideration of the functions pertaining to any organ, it is requisite to understand its structure, or in other words the physiology of a part depends upon its anatomy. The presence of the appendix vermiformis in man and in some of the higher orders of apes, while it is absent in quadrupeds and other inferior animals, may perhaps lead the followers of Darwin to the conclusion that the missing link is to be sought in this development; but I have no inclination to enter into the abstruse questions of evolution, and only regret that we are precluded from receiving any information from a study of comparative anatomy in respect to this unique appendage. If the dog and cat were supplied with this structure, the facility for making experiments upon them might enhance very much our knowledge of its normal and abnormal conditions, whether idiopathic or traumatic; but the door is shut to all such investigation, and the human subject does not fully avail for satisfactory data in regard to its structure and its office. In its general outline the appendix is subject to great variations of size and position, being found in different subjects from three to six inches in length, and lying diversely in its relation to the cæcum. Its diameter admits

of considerable changes owing to the variable contents of the canal, whether gaseous, mucous or serous. This tube is of the same size from its attachment to the lower wall of the cæcum to its termination in a blind pouch at its free extremity; and when empty or occupied only with mucus this measurement is ordinarily about one-fourth of an inch. There is usually a mesenteric attachment to the wall of the cæcum, and this duplicature of the peritoneum invests its entire length, while a muscular layer is found between this and the mucous membrane which lines it. The opening into the cæcal cavity has a valvular arrangement of the mucous membrane which is capable of closing the orifice, and doubtless ordinarily prevents the entrance of foreign bodies into this blind pouch. It becomes dilated, however, under certain circumstances so as to admit of the passage of small solid masses through this orifice, and these become arrested in the tube and prove a source of disturbance. In view of this fact, this valve has been regarded by some writers as a trap, which is very prone to cause obstruction of the canal of the appendix by foreign bodies, as when the latter are once introduced there is perhaps a kind of constriction of the orifice of the appendix which interferes with their escape. That there exist in the middle coat of the appendix longitudinal and circular muscular fibres, which by their alternate contraction and relaxation provide for a serous or mucous exudation, and after certain modifications in it promote its expulsion, is very evident from a study of the histological elements of its organization. Whether or not any considerable proportion of faecal matter enters the cavity of the appendix has not been determined, but it seems most probable that the quantity must be small in view of the relative size of this diminutive tubular sac and the capacious cæcal

¹Read in the Surgical Section of the American Medical Association at the meeting in Cincinnati, May 11, 1888.

pouch which receives the contents of the ileum through the ileo-cæcal valve. The capacity for distension being limited in extent, precludes the view that the cavity of the appendix may serve as a diverticulum in cases of undue accumulation of fecal matter in the colon. An opportunity has been recently afforded me of noting that obstruction of the descending colon from an organic stricture, inducing such distension of its walls by the retained contents as to result in perforation and death, did not materially affect the size of the appendix vermiformis. It cannot, therefore, be regarded as a safety-valve for the cæcum, but is rather to be looked upon as a loop-hole for the entrance of matters prejudicial to it and the adjacent structures; and may be appropriately regarded as a danger signal to warn the organism of approaching trouble.

The location of the orifice of the vermiform appendix at the most dependent part of the caput coli, while the entrance of the ileum through the ileo-cæcal valve is above and at the inner side, affording a direct passage to the contents of the alimentary canal into the cæcum as a receptacle, would seem to favor the conclusion that some change is there brought about by the contact of fecal matter with the discharges from the appendix.

Its mucous lining, according to Gray, is furnished with a large number of solitary glands, and Satterthwaite states in his "Manual of Histology" that "in the vermiform appendix we find the collection of solitary lymph follicles so closely placed that the space left between adjoining glands does not equal in diameter that of these structures themselves."

On the other hand, we learn from Quain that "in man the chief function of the cæcum is absorption, as is shown by the great number of lymphatics in its walls;" while Landois tells us that "the contents assume the characters of feces and become formed in the lower part of the great intestine." The high authority of Littré warrants the assertion that "it is in the cæcum that the residue of the alimentary substances assumes all the characteristics of fecal matter;" and in the absence of other explanation of the peculiar odor imparted to the contents of the colon from this point forward, it is fair to infer that this modification comes from the influence of the appendix vermiformis, either by some chemical or vital process.

I have not such data to hand in support of this view as will stand the test of scientific criticism. Notwithstanding the fact that I am without material for vivisection,

in the absence of wombats and apes, while the opportunities for elucidation from observations upon the human body are few, yet upon the principle of exclusion it is expected that this theory of the function of the appendix may be entitled to consideration. As its province in the animal economy has not heretofore been pointed out by physiologists, I would appeal to them to recognize this hypothesis, on the same basis that the owner of a certain historic dog in the backwoods of North Carolina claimed that he was a good "'possum dog,"—that he had tried him thoroughly for every other species of game without discovering any hunting qualities, and hence he concluded that he ought to be good to catch the opossum. Reasoning upon the general principle that all the organs of the human body are fitted for the discharge of a useful end in the animal organism, we are not warranted in concluding that the appendix vermiformis is an exception to this rule of the fitness of things, and it behooves us to investigate seriously its function. We should satisfy ourselves as to its relations to the digestive and excrementitious processes, with its position as a sentinel at the gateway, without participating, so far as is known, in the work of alimentation or defecation.

The antiseptic property of sulphurous gases is well known, and the presence of sulphuretted hydrogen in the colon cannot be accounted for by any process of decomposition developed in its contents, as the cases of arrest of fecal matter, with or without impaction, are not attended with such results as would ensue from such a process. We are therefore warranted in attributing the absence of any signs of degeneration to the presence of an antiseptic element, which is developed in the vermiform appendix and intermingled with the fecal mass in the cæcum, which serves as a reservoir where this process may be undergone as the residue of the alimentary substances is poured out of the small intestines. The effectual security against regurgitation afforded by the construction of the ileo-cæcal valve, as well as the barrier formed by the valvular opening of the appendix, which prevents the entrance of fecal matter into its cavity, while gaseous emanations or its natural secretion of mucus may pass out into the caput coli—these facts favor the view that an important office belongs to the appendix vermiformis in preserving the contents from decomposition during their progress through the colon, an office beyond that claimed for the admixture of the bile elements with the excrement. It

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is evident that ordinarily the fæces do not enter the canal of the appendix, owing to the nature of the duplicature at its orifice, and when by failure of this impediment, solid matters, fæcal or otherwise, do enter its cavity, there is no capacity in its walls for their expulsion. It therefore follows that in case of such accidents an inflammatory process is developed in the appendix. The number of cases in which the appendix has been removed by operative procedures, or has been obliterated by disease, are thus far comparatively few, and the observations upon the effects of such loss have not been reported in such a way as to throw any light upon the function of this development which characterizes a higher order of animal creation. The vague conception that the appendix is rudimentary in nature seems to have taken possession of physiologists without any show of reason or any foundation in fact, so far as the study of comparative anatomy can aid in directing us to a satisfactory conclusion. If it can be made to appear that the native population of our primeval forests, which subsisted largely upon herbs and roots, with an admixture of animal food, presented any marked increase of development in this respect, it might go towards sustaining this claim. But this hypothesis is far-fetched, and I am not aware of any such facts to corroborate it, nor are there any data available from the history of the human race since the creation of mankind, which tend towards a confirmation of this view; and the attempt to bolster up a theory without facts is only an acknowledgment of utter ignorance.

The increased number of disorders of the appendix vermiformis which have been recognized in these latter years might lead to an inference that it is destined to entire obliteration in the course of time, were it not evident that many affections of the appendix were formerly ignored from the lack of proper observation in diagnosing the troubles of this region. Should it appear in the future that the appendix vermiformis may be removed with impunity, then it will only prove what has been demonstrated in the case of other important members of the body, namely, that they are not essential to the human organism. But no one would undertake to set aside the important office of the ovaries in the rôle of creation, because, forsooth, they have been removed without detriment to the subsequent health and comfort of the individual. It strikes me forcibly that the practice of oöphorectomy resorted to so frequently of late for slight

causes, and in some instances without indications of disease in the organ, may at no distant day be held as an excuse for cutting down upon the vermiform appendix on the slightest provocation, for the purpose of ligating and excising it, and thus ridding the individual of further trouble from its disorders. How far this might be justified from a consideration of the great risk to life attending inflammation and perforation of its walls, depends, in the absence of trustworthy data for an early diagnosis, upon the importance which may be attached to the function of this peculiar structure, after further observation of the effects of its removal; and surgeons must await the result with interest.

Whether inflammation is developed in this structure independent of mechanical irritation from the entrance of foreign bodies or the formation of fæcal concretions, has not been clearly demonstrated. Clinical observation in cases which yield to treatment leave doubts as to the real seat of the disease referred to this region, and so far as noted in *post-mortem* examination the lesions have for the most part been referred to the presence of a mechanical irritant. While some have asserted that inflammation is set up in the vermiform appendage as a result of derangement of the digestive apparatus, and others have supposed that the entrance of germs into its cavity has developed morbid processes in its structure, the facts go to prove that such causes of disease are rare in comparison with the troubles growing out of local irritation of a mechanical origin. It is remarkable that the presence of such foreign bodies rarely produces any serious inconvenience until perforation of the wall of the appendix ensues, and even then the localization of the pain and inflammation is not well defined, either by the sensations of the patient or by objective symptoms recognized in a physical examination by the practitioner. There is an absence of preliminary indications pointing to the nature of the inflammatory process at the incipency of the disorders of the appendix vermiformis, which presents to the surgeon a problem difficult of solution.

At this early stage there may, however, exist a certain degree of sensitiveness upon pressure immediately over the site of the appendix, and this tenderness, revealed by cautious palpation, may serve for the recognition of an incipient inflammation in the appendix, when as yet there is no perceptible thickening or induration of the tissues. It is clear that the effects of the causative influence, of

whatever character it may be, must, up to a certain point, be of gradual operation in the development of inflammation. During this stage it is of the greatest importance to be able to recognize its progress, and not only should the external examination be carefully made, but the digital exploration by the rectum should also be directed to the discovery of the seat of the inflammation in the appendix.

There are in most instances some concomitants of the local trouble manifested in the derangement of the alimentary canal, perhaps of a reflex order, prior to the extension of the inflammatory process to the adjoining structures. In the early history of appendicitis, it has been noted that there may occur either a disposition to frequent evacuations or a state of intestinal torpidity, in which it is difficult to arouse the peristaltic action of the bowels either by purgative medicines or enemata. During this period the constitutional disturbance is not very marked, and yet there exists usually a febrile state, with slight rise of temperature, so that nice discrimination will detect a departure from the normal condition of the general system. While the presence of faecal concretions or other foreign bodies in the canal of the appendix may be tolerated for a greater or less period without any manifestation of trouble in the ordinary performance of the functions of the intestines, there are good and sufficient grounds for the conclusion that intestinal derangement from other sources may become an exciting cause of developing the inflammatory process from the local irritant. The history of cases in which death has occurred from other diseases, present quite a number of instances in which there were unmistakable indications of disease of the appendix which had terminated by resolution. But it is generally found that inflammation set up in the wall of the canal from a mechanical irritant, leads to perforation and extravasation of the contents, accompanied by characteristic shock immediately, and followed by diffused inflammation. This is the dividing line between two distinct phases of symptoms, and whatever may have obscured the case previously, it is for the most part well defined after this grave result. There may be only a circumscribed involvement of the surrounding structures, exciting adhesive inflammation in the serous tissues which shut in the exudation from the cavity of the appendix, thus forming a local abscess. But usually the septic matter permeates in different directions and sets up general peritonitis, with a train of constitutional troubles, attended with marked cerebral disturbance and vital depression.

An observation of a peculiar pain in the penis from the perforation of the vermiform appendage has been reported by Tiffany, and the same marked feature occurred in my two cases of perforation which were verified by *post-mortem* examinations. In the elaborate paper of Fitz on Perforating Inflammation of the Vermiform Appendix, some stress is laid upon the disturbance of the urinary and genital organs. During the first three days following the onset of the pain connected with perforation, micturition is occasionally disturbed. Perhaps unusually frequent on the first day, it is likely to be difficult on or after the third day. In certain instances the use of the catheter is required. The right testicle may be retracted and swollen, in which case the course of the pain is apt to be toward this gland. We can understand how the escape of irritating matter from the appendix should cause trouble by transmitting inflammation to the contents of the abdomen, including the pelvic viscera, but it is not apparent that such disturbance of the urinary and genital organs results from general peritonitis induced by other causes, and the pain in the penis cannot be attributed to the peritonitis. If it should be found that this painful development in the penis is present in the early period of appendicular inflammation, and is not a result of perforation, it would aid very much in making the diagnosis at this stage.

We have the authority of a standard work on pathological anatomy and histology for stating that the most frequent form of inflammation of the appendix is a suppurative one. The appendix is swollen and congested; its walls are infiltrated with pus; at some points there may be necrosis and sloughing of portions of its walls. Within the cavity of the appendix we find faecal concretions or foreign bodies, or nothing (but mucus). Such an inflammation may terminate in resolution, but more frequently it sets up an inflammation of the surrounding tissues. This inflammation may be either a local or general peritonitis or a suppurative inflammation of the parts about the appendix. Less frequently there is a chronic inflammation of the mucous membrane of the appendix, followed by constriction of its upper portion, while the lower part is dilated into a cyst filled with mucus and serum. (Delafield and Prudden.)

Another elaborate treatise on Pathological Anatomy and Pathogenesis, states that typhlitis and perityphlitis imply inflammation of the vermiform appendage and parts around it.

The vermiform appendix is peculiarly adapted to catch and retain substances pass-

ing through the cæcum. Matters which have been swallowed—such as grape-seeds, apple-pips, cherry-stones, and the like—and fæces, may accumulate in the appendage and set up inflammation. Sometimes these become crusted over with phosphates and carbonates, and so form fæcal concretions or calculi. The inflammation thus set up may extend to all the coats of the appendage, and then attack the contiguous structures, and in this way necrosis and gangrene, with perforation, may be caused. The issue differs in different cases. It is comparatively favorable if the inflammation continues to be circumscribed, while the exudation is moderate in amount; protective adhesions and false membranes may thus be formed about the affected spot. It is very unfavorable when perforation takes place before adequate adhesions are formed; fatal peritonitis is nearly always induced. When perforation takes place into a part of the peritoneum shut off by adhesions, a burrowing fæcal abscess is produced, which may burst internally or externally. Sometimes the appendage is entirely obliterated by adhesive inflammation; but if the inner or intestinal end becomes closed while the remainder continues to be patent, the natural mucous secretion may collect in the latter and distend it into a cyst. It is likewise specially noted that tuberculous and typhoid ulceration, localized in the vermiform appendage, may give rise to dangerous lesions. (Ziegler).

It is not out of place to repeat what has been stated by me in another recent publication, that I cannot acquiesce in that view of pathologists which attributes the degeneration of the cæcum and appendix to a low state of vitality in their tissues, but on the contrary I hold that they are highly vitalized, and that it is from being overtaxed in the performance of functions essential to the discharge of the excrement, that they are so subject to disease. I agree with Agnew in considering inflammation as hypernutrition, and consider that it is an effort of nature to restore the equilibrium of the circulation which has been interrupted by a local morbid impression from the causative agent. This inflammatory process is an attempt at recuperation of the injured part, and within certain limits it is salutary; but when it transcends the powers and capacities of the organism, I infer that from the undue excitation and over-action of this extraordinary impulse there is a breaking down of the forces of the organization, which leads to disintegration and death of the structures involved. By the development of inflammation in the tissues of the cæcal region,

nature is resenting an insult to the components of this organ, and when it triumphs over the difficulties encountered, resolution ensues; but if it fails, there is ulceration and perforation, leading to abscess and peritonitis. To illustrate the important vital connection of the ileo-cæcal structure with the general organism, I may refer to the fatal results of the resection of this division of the intestinal canal in dogs, reported in my paper in *Gaillards Journal* on Obscure Impediments of the Intestinal Canal, while resection of a portion of the ileum was followed by complete restoration of the intestines. These deaths occurred in less than twenty-four hours, indicating that they were the effect of shock, which can be explained only upon the basis of a most intimate association of this structure with the organic nervous system.

Being therefore convinced of the traumatic reaction on the part of the cæcal division of the intestines as a consequence of injuries or morbid impressions, I would urge a prompt recourse to curative measures.

In regard to the procedure for the treatment of the diseased appendix, all writers are pretty well agreed upon using anodynes and keeping the patient at rest in the early stage with soothing fomentations over the iliac region; but some have resorted to a mild purgation or to an enema to secure evacuations, when the bowels are bound at the outset, and afterwards use opiates in full doses continuously. It may be put down as a dogma in the management of incipient cases of appendicitis that perturbation of every kind is hurtful, and that masterly inactivity should be observed with a view to promote resolution of the inflammatory process if this be possible, thus averting suppuration and perforation. With the uncertainty which hangs over the diagnosis in the early stage of appendicular disorder, the expectant treatment is generally recognized as the most prudent course, but there is a growing tendency among surgeons to cut the Gordian knot by a decisive step, and use an exploratory operation by incision for determining the exact seat and character of the disturbance. Aggressive practitioners, such as Bull and Weir, with others, have inculcated surgical interference at the earliest practicable period, and with the lights before us in cases of this kind the surgeon is warranted, so soon as he has good and sufficient reason to believe that there exists progressive inflammation of the appendix, in verifying this diagnosis by cutting down upon it. This course is indicated when the

symptoms of a local and constitutional or general nature are such as to raise a presumption in favor of appendicular inflammation, in advance of those phenomena which usually accompany perforation. In other words, an exploratory operation is advisable with a view of learning the exact condition of the parts involved. In the event of finding no evidence of inflammatory action in the tissues of the appendix or cæcum, and when no indurated mass can be discovered by palpation in either, after careful exploration the incision may be closed without any probability of serious consequences.

If, however, on the contrary, appendicitis is verified, with or without the recognition of a solid body within its canal, it would be proper to ligate or suture the cæcal attachment, and excise the appendix vermiformis as a security against further inflammatory developments in its structure. Thus, all liability to the graver results of perforation would be most effectually obviated, and thus surgery of a destructive order would eventually prove to be conservative in preventing other grave consequences. The diagnosis of appendicular disorders cannot be guaranteed without an exploratory operation, as the statements of those most familiar with this class of cases show most conclusively, and it cannot augment materially the risk to life, while it insures a radical cure when disease exists.

An incision may be made outside of the right rectus muscle. The extension of the opening upward along the linea semilunaris would be indicated in case a suppurating track should be discovered, as was noted in my case of perforation of the appendix.¹ This was shut off from the general peritoneal cavity by adhesions, so that it left the iliac fossa and reached the diaphragm on the right side, burrowing behind the liver in the form of a cloaca, which could not have been explored properly by an incision in the linea alba, owing to the adhesions existing there between the intestines and the abdominal wall.

In a recent laparotomy for volvulus of the ileum, near its cæcal connection, such difficulty was encountered in the exploration of the seat of disease through an incision in the median line from the umbilicus to the pubes, that it was found necessary, in order to effect my object, to extend my incision upwards to a point midway between the umbilicus and ensiform cartilage. The walls of the intestine involved in the twist were agglutinated and the canal entirely occluded, and there

was also disintegration of the ileum on each side of the obstruction. The cæcal segment was ligated, and the other was cut beyond the gangrenous line and stitched into the median incision, as is done in the process for artificial anus upon closing the abdomen.

If the site of the trouble could have been known in advance, as is presumed to be the case in appendicitis, it would certainly have required a shorter incision in the linea semilunaris than was found necessary in the linea alba in the case just referred to. I avail myself therefore of the opportunity to modify my criticism in the paper read at Chicago, upon the opening of the abdomen at the outer border of the rectus muscle, and fully realize its advantages in operating for appendicular extravasation.

The great advantage of the several steps consists in adapting the extent of the operative procedures to the nature of the case. If there be a doubt in the diagnosis of appendicitis it is solved by a transverse incision in the iliac region, and if nothing be revealed requiring further surgical interference, the opening may be closed by suturing the peritoneum with catgut in continuous form, while the fascia, muscles and skin are brought together by interrupted sutures of iron-dyed silk. There will not occur much strain upon the suture in this line of union, and the operation should not be carried further except when the evidence of disease in the adjacent structures demands a larger field of observation. Incisions along the linea semilunaris upward or downward, with the turning aside of the corresponding flaps, will afford ample scope for operation in cases of circumscribed abscesses in general peritonitis, resulting from the perforation of the appendix vermiformis.

It has been my object in this paper to direct attention to the early development of inflammation in the structure of the appendix, as its progress and termination in perforation have proved serious in most cases; and the intractability of the consequences produced by extravasation of its contents, as manifested by suppuration and peritonitis, is generally recognized by surgeons.

I am not prepared to assert that a differential diagnosis of appendicitis can be assured prior to perforation, but a reasonable presumption in favor of the seat of the disorder being in the structure of the appendix, may be reached by a careful examination of the local signs and the general symptoms. In view of the strong probability of the existence of appendicular trouble it is asserted that an exploratory operation is justifiable in

¹MEDICAL AND SURGICAL REPORTER, April 30, 1887.

advance of any indications of perforation, thus choosing the lesser evil of an unnecessary incision, rather than risk the greater in the calamitous results of extravasation of the contents of the appendix into the peritoneal cavity, accompanied by shock and followed by septicæmia.

The difficulties which the surgeon must encounter from delay in resorting to an operation until perforation assures him of its necessity, should warrant him in forestalling the danger by an exploratory incision so soon as he becomes impressed with probability of appendicular inflammation; and if this belief is realized, the exploratory operation is made a radical operation.

THE POST-NASAL SYRINGE A CAUSE OF MIDDLE EAR DISEASE; WITH AN ILLUSTRATIVE CASE.

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Notwithstanding the fact that a warning note has been sounded from more than one source concerning the disastrous consequences to the middle ear that may result from flooding the naso-pharyngeal space with fluids, medicated or otherwise, the numerous journal reports, together with the recommendations in many of the recent special treatises, particularly foreign publications, on diseases of the rhino-pharynx, attest to the recklessly indiscriminate employment of methods of this character for cleansing and medicating the nasal and pharyngeal cavities.

The first to call attention to the occurrence of otitis media following the use of the nasal douche was Dr. D. B. St. John Roosa, of New York, who, in 1869, reported¹ an example of acute suppurative inflammation of the middle ear with ulceration of the membrana tympani arising in this manner; and then later, with an amplification of this case, he published² a table of sixteen instances of middle ear disease produced by the douche, occurring in the practice of different surgeons. At the same time he gave admonitory advice against the rough or careless use of the posterior nares syringe in acute or subacute catarrh, instancing an example of acute aural catarrh with drum perforation occasioned thereby; and

since then these statements have been confirmed by numerous observers, who have noticed and recorded similar facts regarding both the douche and the syringe.

It is true, however, that not a few rhinologists believe these views to be erroneous, asserting that the douche, besides being a most useful appliance in the treatment of rhino-pharyngeal diseases, when properly and carefully handled is entirely devoid of ill effects, and this opinion they support by a weighty array of statistics; but, it must be conceded that there is already on record a sufficient number of such mishaps in the hands of prudent and skilful surgeons to demonstrate that this and like measures are not so positively innocuous as is claimed by their advocates.

The subjoined case is an additional illustration of this fact, and is of especial interest since it shows that the post-nasal syringe, although fully recognized as not altogether harmless—but, at the same time, considered quite safe in comparison with the douche—is an instrument which must be employed with the utmost caution and circumspection.

Sallie —, a little girl of 12 years of age, who had been under my professional care at intervals during a period of two years for a chronic rhino-pharyngitis associated with middle ear catarrh, reapplied in January, 1887, on account of a slight return of the nasal and aural symptoms. She now received, as formerly, the usual treatment by sprays, powders, etc., each application being preceded, of course, by inflation of the Eustachian tubes, and the use of an alkaline cleansing solution applied by means of the ordinary post-nasal syringe.

The syringe had been employed in this manner a great many times without any unpleasant effects whatever, although no especial precaution had been observed in its application. At 11 A.M., on January 20, I proceeded to cleanse the nasal spaces in the same way, using for this purpose Dobell's solution with "Listerine." At the instant the fluid was discharged from the syringe she complained of a sharp, cutting pain in the left ear, which caused her to cry out, and clasp with her hand the painful ear. The fluid was injected slowly and gently, not forcibly, but I noticed that there was a decided spasmodic action on the part of the pharyngopalatal muscles which tightly grasped the extremity of the syringe. The intensity of the pain subsided in a few moments, but a dull, heavy ache remained until after the use of a hot water douche; and examination revealed an injected and congested drum

¹ *Archives Ophthalmology and Otology*, Vol. 1, No. 1.

² "Practical Treatise on Diseases of the Ear," fifth edition, p. 296, 1881.

membrane, but no bulging. She remained in my consulting room until all pain had disappeared, when she was sent home with instructions to summon me upon the slightest recurrence of suffering. This was not obeyed, however, and I learned that the pain returned in about an hour after leaving my office. This, at first, was throbbing in character, accompanied by a full, heavy sensation in the face and head on the affected side, and becoming exquisitely intense as evening approached. Her mother employed opium, both internally and locally, hot fomentations, etc., but with very little relief until after daylight when the pain suddenly began to lessen and was quite gone within a half hour. Coincident with the subsidence of the pain she noticed a sanguineous discharge, which saturated a plug of cotton-wool, placed in the meatus to retain the anodyne applications, and trickled down upon the pillow. I saw her at midday (January 21), when a small quantity of half-dried bloody fluid was found in the external tube, and a rent in the posterior and inferior quadrant of the membrana tympani plainly visible.

Active measures were immediately taken, and very fortunately the case went on to complete recovery: the perforation healed rapidly, hearing soon rose to the normal, and within the space of a few weeks there was nothing to indicate the occurrence of the accident.

The injurious action of the douche is rightly attributed by Dr. Roosa to the direct passage of a flood of liquid into the tympanic space; but he evidently considers the syringe as harmful only through its irritative or abrasive action to the pharyngeal mucous membrane around the tubal openings—the inflammation thus originating extending along the Eustachian tube to the tympanum—as is shown by the following paragraph, referring to its use: "In cases of acute inflammation of the pharynx attended with considerable swelling, it should be used with care, or it will abrade and irritate the mucous membrane of the pharyngeal wall. This abrasion may then lead to an extension of the inflammation along the tube to the tympanic cavity. *In chronic cases I have never seen or heard of any harm being done by the posterior nares syringe.*"³ The italics are mine.

In the present instance the acute aural catarrh was undoubtedly the immediate result of the entrance of liquid into the cavity of the tympanum, since the sudden sharp

pain at the moment of injecting the fluid can be explained in no other rational way.

It is very clear, therefore, that the nasopharyngeal syringe may be productive of harm in both acute and chronic cases, and by two methods: first, the direct entrance of liquid into the Eustachian tube and tympanum; and, second, an irritation or abrasion of the mucous membrane around the faucial extremity of the tube, produced by the syringe nozzle, leading to an inflammation which quickly advances along the canal to the sensitive and repellent tympanic cavity.

Whilst I do not wish to be understood as absolutely condemning the posterior nares syringe as an instrument which should be discarded from the armamentarium of aural and pharyngeal appliances, I am desirous of emphasizing the necessity of exercising the greatest care and gentleness in its employment, and, also, of restricting its use to a much fewer number of cases. When it is used, it should never be emptied of its contents with a jerk by suddenly and forcibly driving the piston home, but the liquid should be gently and slowly discharged in a continuous stream; and should a spasmodic grasping of the syringe point take place, the instrument should be either withdrawn entirely, or allowed to remain quietly in position until the pharynx becomes tolerant of its presence, or, perhaps, local anaesthesia of the pharynx may be resorted to with advantage.

Leaving out of consideration the practical lesson furnished by this case, I am opposed on general anatomical and physiological grounds to flooding the nasal and pharyngeal spaces with any considerable volume of liquid; and, furthermore, I am convinced that the spray is the only sensible and effective method by which these cavities may be safely cleansed or medicated.

N. E. cor. Joachim and Conti Streets.

—At a recent meeting of the Agricultural Society of Paris, M. Torney, professor of arboriculture, put in a note on sewage water. He thinks that the culture of the Jerusalem artichoke would suit very much better than that of any other ordinary vegetable for the rapid absorption of matter in suspension in sewage water. The Jerusalem artichoke attains a height of eight to ten feet, which does not admit of the wind getting to substances on the surface of the soil, and so prevents to some extent the propagation of epidemics.

³ "Treatise on Diseases of the Ear," p. 291.

LOCAL APPLICATION OF BALSAM OF COPAIBA IN INFANTILE LEUCORRHOEA.

BY J. B. JOHNSON, M.D.,

WASHINGTON, D. C.

Leucorrhœa is common to women of all ages. That of young female life is most commonly limited to the vulva; and it is the exception for the inflammation which excites the discharge to extend far into the vagina. When the inflammation does reach into the vagina, the disease is usually quite severe, and is attended with a copious discharge and swelling of the vulva, accompanied by heat, pain and distressing itching. When the labia are separated with the fingers, the mucous membrane, not only of the labia but of the mouth of the vagina, will be seen to be intensely red, tumefied and covered with an unhealthy looking muco-purulent discharge, varying in color from a white to a yellow or greenish hue, and resembling in external appearance the discharge of gonorrhœa. This resemblance of the leucorrhœal discharge to that of the gonorrhœal, sometimes gives rise, in the minds of parents, to the supposition that their child has been criminally dealt with; but such an impression will be easily dispelled not only by the history of the case, but by the absence of marks of injury from criminal violence, which when present usually cause rupture of the hymen, bruising and swelling of the labia and surrounding parts, attended with a more or less copious trickling of healthy blood from the wounded tissues of the external genital organs.

The most common exciting cause of the disease I have found to be an herpetic or eczematous eruption about the vulva, which, in consequence of the intense pruritis excited by the presence of these eruptions, forces the child to scratch and rub her parts with violence, creating not only much irritation to the vulva but also to the vagina. This repeated and excessive rubbing of the external organs of generation by the child with her hands, is often the first sign which leads the mother to investigate the cause of the child's uneasiness; and upon examination the mother generally finds the labia red and swollen, and covered with scaly incrustations of the dried discharge, and upon separating the lips of the vulva she will see purulent or muco-purulent matter issuing from the vagina, and the presence of the disease is thus ordinarily detected and confirmed. Scrofulous girls are most susceptible to this disease. It some-

times occurs during or follows an attack of scarlet fever, and does occasionally arise from cold and from infection. During its progress it is much aggravated or prolonged by the existence of dentition, worms or constipation. Its predisposing cause resides in an innate liability to inflammation of the mucous membranes, which is now and then seen to be a part of the constitutions of some individuals. As there are persons born to great liability to inflammation of the serous membranes, so there are those who come into the world with a high susceptibility to inflammations of the mucous membranes; and it is this diathesis that explains why a child may have infantile leucorrhœa from "cold," caused by insufficient clothing of the lower extremities, or from sitting on the damp ground, or upon cold surfaces of door steps or stones.

The discharge is highly contagious, and a healthy girl child may be infected by sleeping with one who has the discharge; and a child so affected should not be allowed to sleep in the same bed with another child or even with its own parents, for instances have been known of mothers being infected by sleeping with their little daughters while suffering with the disease, which often maintains a tedious course of several weeks or more. The cloths and towels used to dry the parts of girls thus affected, should never be used to wipe the face, or indeed any part of the body; for if the slightest portion of the discharge should get into the eyes, acute and dangerous ophthalmia is almost certain to be excited. In order to guard against such accidents, the mother should always be informed of the activity of the contagious character of the discharge of infantile leucorrhœa.

Treatment.—This disease will persist in being very tedious in its course, if absolute cleanliness and partial rest are not firmly insisted upon during the application of the remedial measures which may be adopted for its cure. The mother should be instructed to wash well the external genital organs of the child at least four times a day; and this cleansing should be performed in the morning as soon as the child gets up, and at noon and evening, and just before the child goes to bed. As a wash for this purpose, I usually order the following, to be used tepid, in cold weather:

R Pulv. borax.....3ij
Water.....f ʒv
Glycerine.....f ʒj
Carbolic acid.....gr.x

M. S.—Shake well and use four times a day.

After the parts have been well washed, I order finely powdered oxide of zinc, or oleate of zinc, to be freely sprinkled, or powdered between and over the lips of the vulva. Ordinarily, I find this simple treatment to cure the case; but unfortunately, the disease often extends from the vulva far into the vagina, giving rise to severe vaginitis; and when I meet with a case in this condition, I am in the habit of relying upon the local application of balsam of copaiba for its cure. After each washing, I direct three or four drops of the copaiba to be dropped into the mouth of the vagina, and allowed to remain there, and to diffuse itself over the various parts of the vulva. The dropping of the copaiba into the vagina should be conducted while the child is lying upon its back, with its hips elevated by a pillow, and the labia majora separated as widely as possible; and the child should be allowed to remain in this position for five or ten minutes after the application of the copaiba. Should the pure copaiba excite too much irritation, it may be mollified by mixing with equal portions of cocoa-butter or carbolized vaseline, and put into the vagina with a camel's-hair-brush as far as this is practicable. While the local treatment is in progress, I prescribe the following as a tonic and alterative:

R Sulph. magnesia.....	ʒj
Caraway water.....	f ʒviii
Iodide of potassium.....	ʒij
Fowler's solution.....	f ʒj

M. S.—Shake well and give one teaspoonful to a tablespoonful, three times a day, according to the age of the child.

When severe pain in micturition attends the discharge, it will be found to be caused by fine inflamed points of mucous membrane situated about the orifice of the urethra, and these projecting points are most quickly destroyed by the application, once in every two or three days, of nitrate of silver. During treatment, the child should not be allowed to go to school, and should be restricted in its usual exercise. Indeed, the less exercise the child is allowed to take, the sooner will a cure be attained; and this fact should be impressed upon the mind of the mother; and she should also be informed that the treatment should be continued in a less rigid manner for several weeks after the discharge has disappeared; for if this rule is not observed, the discharge will most certainly return after its apparent disappearance. The diet should be generous and nutritious; while those articles of food apt to irritate the alimentary canal should be strictly forbidden.

DEATH AFTER ADMINISTRATION OF CHLORAL IN LABOR; FIRM CONTRACTION OF THE UTERUS.

BY JACOB R. LUDLOW, M. D.,
EASTON, PA.

A woman, about eighteen years of age, primiparous, came under my observation some time ago, suffering from puerperal eclampsia at full term. She had been bled from both arms, had taken chloroform inhalations, and, during the night, two rectal injections of chloral hydrate—at least eighty grains in the two injections.

When I saw her the next morning, she was pallid, entirely unconscious, with a small, feeble pulse—about 120, with shallow, frequent, noiseless respirations, and extreme contraction of the pupils. There was very great œdematous swelling of the lower extremities. Finding the os dilatate, I produced podalic version, and in about thirty minutes delivered a large male child, still-born, flaccid, with the appearance of having been dead some hours. I operated slowly, regardless of the life of the child, fearing to encounter atony of the uterus with immediate fatal hemorrhage; but the uterus contracted firmly and the secundines came away without trouble. After the delivery she did not manifest any noticeable change. She seemed in good condition except for the extreme anæsthesia.

I saw her by request the next morning, about twenty-four hours after her delivery. Her condition was unchanged, still pale, with pulse and respiration as when I left her the previous day, perfect unconsciousness and loss of voluntary motion, the conjunctival reflex and deglutition abolished. The uterine globe was firm and distinct, and there had been absolutely no leakage. The œdema of the legs was considerably diminished. She was ordered whiskey per rectum, but died the following night, about thirty-six hours after delivery.

Perhaps the most noticeable thing in this case is the lethal anæsthesia, with abrogation of deglutition, voluntary motion and consciousness, with cardiac and respiratory centres almost paralyzed, and this persisting continuously for more than thirty-six hours; while yet the innervation of the uterus was unaffected and the womb retained its tonicity to the last.

I think it is fair to infer from it that chloroform and chloral hydrate do not in any degree impair the power of the centres which give energy to the uterine contractions.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, April 11, 1888.

The President, J. SOLIS-COHEN, M.D., in the Chair.

Dr. J. M. BARTON read

A Report, and Exhibited the Specimens, of Some Cases of Abdominal Surgery.

By invitation of the Board of Directors of the Philadelphia County Medical Society, Dr. Barton submitted some specimens from cases of abdominal surgery and presented the notes of them:

"Case I.—Abscess of liver. Free incision and drainage; recovery.—George B., aged thirty-eight years, was admitted to the medical wards of the Jefferson Medical College Hospital, July 29, under the care of my colleague Dr. Neff. The patient was suffering with an immense abscess of the liver, extending the area of the percussion dulness to below the umbilicus and to the left of it. At the request of Dr. Neff, I removed by aspiration more than a quart of "brick-dust" colored pus, with such relief that the patient was able to return to his home in the interior of the State. The abscess cavity rapidly refilled, and he returned to the hospital, when we decided to operate by the method of Dr. Ransohoff, of Cincinnati: making an incision through the abdominal wall, five inches in length, at the outer edge of the right rectus muscle, permitting it to gape, fastening the edges of the wound by sutures to the liver, and when firm adhesions had taken place, opening the liver by the galvanic knife. When adhesions were found to have formed, and I attempted to divide the tissues of the liver with the galvanic knife it did not act well; at first, while white-hot it would cut readily, but the resulting very free bleeding quickly short-circuited the current and the knife became instantly cold. After repeated trials it still proved so unsatisfactory that an ordinary scalpel was substituted, with which the pus cavity was reached. An attempt to check the bleeding from the margins of the incision, by the cautery knife, was also unsuccessful, and it was only by filling the wound with a number of rubber catheters, which happened to be at hand, that the hemorrhage was controlled.

The abscess cavity was washed out daily with various antiseptics; it gradually closed, and the patient was discharged cured. When

Dr. Neff saw him the following December, his weight was one hundred and fifty-six pounds, his pulse beat eighty to the minute, and he had no evidence of hepatic disease."

Case II.—This was a case of epithelioma of the cesophagus, in which gastrostomy was done and death resulted. The patient was a man 42 years old.

Case III.—This was a case in which an unmarried woman, 36 years old, had a large uterine fibroid. On making an exploratory incision it was found that universal adhesions would prevent the removal of the uterus or of the ovaries. The patient recovered.

Though previous to the operation she almost invariably bled for ten days at each menstrual epoch and at least twice between the menstrual flows, immediately after the operation the excessive bleeding ceased, and for nearly two years she regularly menstruated but three or four days; she did not lose more than one-fourth of the quantity each day that she had prior to the operation and there was no bleeding whatever between the menstrual periods. Her pains have ceased since the operation, her general health has greatly improved, and she looks much younger. Ever since the operation she has been, and is now, following her occupation as a school-teacher. Nothing was done at the operation to account for this improvement, which is great enough to have been considered quite a success if the ovaries had been removed. The tumor is gradually increasing in size, and is now beginning to interfere with respiration.

"The next case is one of so much interest that I am anxious to have it on record, though the principal part of the operative treatment was not performed by myself. The laparotomy was performed by my colleague, Dr. F. H. Gross, when I was a member of the staff of the German Hospital, during his term of service; the herniotomy by myself during my term, though we were both present, and took active part in both operations. I am indebted to Dr. Gross for permission to report this case:

"Case IV.—Strangulated hernia. Operation; loss of nine inches of intestine; subsequent laparotomy; several feet of bowel found obstructed by inflammatory deposits; bowel above the obstruction joined to bowel below the obstruction; recovery.—Frank F., aged 18 years, was admitted to the German Hospital on the evening of March 3, 1884, with a strangulated right inguinal hernia of eighteen hours' duration. On opening the sac of the hernia nine inches of the bowel was found to be in a sloughing condition. The ring was nicked, the healthy ends of the bowel

made to protrude, and the gangrenous portion incised. We proposed, on the next day, to freshen the edges of the healthy bowel and bring them together. By the following morning the patient had developed an intense peritonitis with a temperature of 104° , and the operation was postponed. After a week of severe illness he recovered, the sloughing bowel having separated in the meantime.

Some weeks later, as he was slowly emaciating, and the discharges looked as though the artificial anus was high up the bowel, operative interference was decided upon. The wound was enlarged, directly upward, at first but slightly, but ultimately to the extent of several inches, for the purpose of joining the divided ends of the bowel.

In the neighborhood of the artificial anus from two to three feet of intestine were found, strongly matted together by inflammatory deposits; small projecting loops of a few inches in length were found free with both ends terminating in the mass. The lower end of the bowel, from which the slough had separated, could not readily be distinguished from any of the other loops; and it soon appeared that it would be useless to join it to the bowel which formed the artificial anus, as it was completely obstructed at many points. As the colon was free, and a few inches of the ileum, at the suggestion of Dr. Weed, then one of the resident physicians, it was decided to join the bowel forming the artificial anus to the colon. For this purpose a small opening was made in the cæcum, and one blade of Dupuytren's enterotome introduced, the other being carried into the bowel forming the artificial anus, and the two blades clamped together. A temporary ligature was placed around both intestines while the toilette of the peritoneum was made; they were then fastened in position, and the wound, about six inches in length, closed.

The patient did well after the operation, though it was found necessary to reapply the enterotome twice before a satisfactory opening was obtained, three times in all. The fæcal fistula rapidly contracted, and when I last saw him he was able to wear a pad over it for a week without removal; his bowels acted naturally, he was free from pain, gaining flesh, and was working as elevator boy at the hospital.

I heard afterward that another surgeon had attempted, though unsuccessfully, to close the fistula."

Case V.—This was a case in which a married woman, fifty-four years old, had an ovarian cyst which ruptured. Ovariectomy

was performed, and the patient died on the fourth day.

Case VI.—This was a case in which a man, thirty-one years old, had an encysted pelvic abscess. The abdominal and visceral peritoneum were stitched together, the abscess emptied and drained, and the patient recovered.

Case VII.—In this case double ovariectomy was performed on a married woman, twenty-eight years old, for multilocular cysts, weighing about forty pounds. The patient recovered.

Case VIII.—In this case a large fibroma of the uterus was removed from a married woman, thirty-two years old. The uterus and ovaries were removed by abdominal section, and the patient died on the fourth day.

"Case IX.—Stricture of the ileo-cæcal valve, chronic obstruction of the bowels. Laparotomy; digital dilatation of the stricture; recovery.—Mrs. Ann H., aged thirty-seven years, a patient of Dr. D. S. Jones of Plymouth, Pennsylvania, was admitted to the Jefferson Medical College Hospital in May, 1887. She had been in good health until the birth of a child in May, 1886. Since then she had had repeated and increasing attacks of obstruction of the bowels; during which there were entire loss of appetite, obstinate constipation, constant vomiting, great abdominal pain, and tenesmus, similar, she stated, to labor pains. Lately there had appeared at these times a tumor about the size of the adult fist in the lower part of the abdomen; these attacks occurred about once a month, and as they lasted three weeks she had but a short interval of comfort between them. When free from the attack, she stated that the tumor returned to the right iliac fossa, where she thought she could distinguish it by palpation and by its tenderness on pressure. I was unable, at this time, however, to recognize any unusual mass in this situation.

I kept her under observation until an attack should occur. On May 21 an attack began, and her sufferings fully verified her statements. The tumor appeared between the umbilicus and the pubes, it was about the size, and very nearly the shape, of the adult kidney.

On May 2, 1887, in the presence of Professors Gross, Parvin, Brinton, and several other physicians, I made a median incision about four inches in length and exposed the mass; it proved to be an intussusception of the ileum into the colon with a thickened and contracted ileo-cæcal valve forming the apex of the intussusception. There were

slight adhesions between the contiguous layers of peritoneum covering the bowel, which were readily broken up, and the intussusception reduced. On examining the ileo-cæcal valve by a finger invaginating a fold of the colon, it was found to be hard and contracted. A longitudinal incision was made in the colon about one inch in length, and three from the valve, through which I passed my finger and found the valve contracted to about the size of a crow's quill (one-fifth of an inch). It was slightly thickened, quite hard, white in color, and did not bleed during the examination or subsequent manipulations. It was considered by all present to be a case of cicatricial stenosis due to some previous inflammatory action, and certainly not malignant. It was dilated, with considerable difficulty, by the introduction of the little finger, and the index finger was then carried through its entire length.

The wound in the bowel was closed by a continuous silk suture, including only the mucous membrane; the peritoneal coats were brought in apposition by a continuous silk Lembert suture.

All the operative procedures upon the bowel were performed outside of the abdominal cavity, the abdominal wound being kept closed by sponges. The portion of bowel outside was thoroughly washed and returned, the abdominal wound was closed in the usual manner.

There was some vomiting after the operation; the patient was kept slightly under the influence of morphine for a few days, and on a milk and broth diet. The bowels opened naturally on the eighth day, the stitches were removed on the fifth and sixth days; the temperature never rose above 100° . She returned to her home entirely free from all her previous symptoms, and remained free for several months."

[For her subsequent history, see Case XIII, page 600].

"Case X.—Obstruction of the pylorus. Digital dilatation by Loreta's method; death from exhaustion.—George H., German, aged fifty-eight years; blacksmith. His health had always been good until the last year. At the time he came under my care he had the typical symptoms of complete pyloric obstruction, with a well-marked tumor at the usual situation. It was not very large nor hard, had no marked outlines, and presented the characters of pyloric thickening more than those of a malignant growth. The microscopical examination of the matters vomited gave no evidence of malignancy, and no vomiting of blood had occurred. He

was greatly emaciated, and so feeble that at first I refused any operative interference; the operation had, however, been explained to him, and its performance promised before he came under my care, and he insisted so strongly on having a chance for prolonging his life that I consented.

The operation was performed at Jefferson Medical College Hospital May 22, 1887, in the presence and with the assistance of Professor Brinton, Dr. Wirgman, and quite a number of others.

As the patient's condition warranted no further interference than mere dilatation of the pyloric orifices, and as the usual incision to the right of the median line would have exposed the stomach nearer to the pyloric orifice (as shown by the position of the tumor) than I desired, I made the incision directly in the median line, and about three inches in length, beginning an inch and a half below the ensiform cartilage.

The stomach was readily exposed three inches from the pylorus. The examination of its exterior threw no new light on the character of the growth, though the stomach at this point was found to be slightly adherent to the structures beneath. An incision, a little over one inch in length and three inches from the pyloric orifice, was made in the stomach, parallel to and directly beneath the abdominal incision; the coats of the stomach were much thickened. Complete stenosis of the pyloric orifice was found when the finger was introduced, but this was readily dilated with the little finger. While the tumor was supported outside the abdominal walls with the left hand, the orifice was then further dilated with the index finger.

The thickening and infiltration of the walls of the stomach at the point of incision prevented the use of the Lembert suture; their softened condition evidently required the suture to pass through all the coats. As the abdominal wound was directly over that in the stomach, the latter was closed and brought in contact with the abdominal wound, so that the visceral and parietal peritoneum might adhere, and if any of the contents of the stomach should escape or any pus form, they might readily drain outside and not into the general peritoneal cavity. Fine silk with two needles were used, these were carried from within outward through all the coats of the stomach, one needle through each lip, then crossed and one brought through each lip of the abdominal wound; a few were carried direct without crossing. These sutures were tied and the abdomen closed.

Nothing was given by the stomach for the first twenty-four hours, the rectal nourishment upon which he had relied previous to the operation being continued. No vomiting occurred during the four days that he lived. On the second day milk and hot water were given in small doses at regular intervals, and as they were well borne they were increased in quantity and frequency. Notwithstanding the fact that he took over a quart of milk per day, besides rectal nourishment, he sank and died exhausted on the fourth day after the operation. There had been no elevation of temperature.

At the autopsy the stomach was found firmly fastened to the abdominal wall; there was no evidence of any peritonitis. In the interior of the stomach it was difficult to find the point at which the incision had been made, the sutures being completely buried in the folds of the mucous membrane. The pyloric thickening was inflammatory in character, and not due to any malignant growth.

There was complete obstruction previous to the operation, there was none after, and had the patient been subjected to operative interference earlier there is no reason why his life might not have been greatly prolonged."

"Case XI.—Ovarian tumor. Removal; recovery.—Miss A., aged thirty-eight years, had noticed a pain less abdominal enlargement for a few months. On examination I found a small ovarian cyst, lying in the median line and rising slightly above the umbilicus. On May 23, 1887, with the assistance of Drs. Da Costa, Edward Graham, Sweet and Fisher it was removed. The incision was about three inches in length, the tumor was non-adherent. It was tapped, drained, and removed in the usual manner; its pedicle was tied with silk and dropped.

The peritoneum was brought together with chromicized catgut, the interrupted silk suture being used for the other tissues. The patient made an uninterrupted recovery, her temperature never rising above 99°. The tumor weighed about fifteen pounds."

"Case XII.—Two penetrating stab wounds, one puncturing the liver and one the transverse colon. Laparotomy; recovery.—Michael H., aged twenty-five years, was admitted to the Jefferson Medical College Hospital at 3 P.M., of September 9, 1887. About three hours previously he had been stabbed twice with a small and pointed amputating knife, during a quarrel in a house of ill-fame.

There were two wounds, both penetrating the abdominal cavity, both at the outer edge of the right rectus muscle and both running diagonally toward the median line, and pen-

etrating the peritoneum at that point. The upper was one and a quarter inches long and was just below the edge of the ribs; it terminated in the left lobe of the liver, and from it there was free venous bleeding.

The lower wound was three-quarters of an inch long; it was three inches below the upper and just above the level of the umbilicus. After hurried antiseptic preparations, I opened the abdomen in the median line from the ensiform cartilage to the umbilicus, and found an opening about five-eighths of an inch in length in the transverse colon parallel to its length and near its mesenteric attachment; this was closed by the continuous silk Lembert suture. The suture failed to control a small artery in this wound, but a separate stitch carried under it and tied secured it.

The wound in the liver was small, it had ceased oozing, and as its lips were in fair contact no suture was used. The abdomen was cleansed, the wound closed and dressed in the usual manner.

The following morning his temperature was 101° and in the evening 100°; after that, though it kept quite low, varying from 98½° to 99°, he had a sharp attack of peritonitis, lasting three days, during which time there was constant regurgitation of bloody fluid. The abdomen was painful and greatly distended with gas, requiring the constant use of the long rectal tube to relieve him. The stitches were removed on the fourth and fifth days, and the abdomen supported by adhesive plaster. He was discharged cured on September 29, having been in the hospital twenty days."

"Case XIII.—Epithelioma of the ileo-cæcal valve. Resection of three inches of intestine; recovery.—Mrs. H., aged thirty-eight years, the same patient whose ileo-cæcal valve was dilated seven months before (see Case IX, page 598), came complaining of a return of her former symptoms; her sufferings were slight, but were evidently of the same character as before the first operation.

November 1, 1887, with the assistance of Drs. Allis, Kendig, Stillwell, and the resident staff, I again opened the abdomen. A straight incision parallel with the median line was made; it was three inches in length terminating at a point one inch outside the middle of Poupart's ligament. The incision was made at this point as the nearest to the portion of bowel I wished to attack, because I feared adhesions might have formed after the last operation, rendering it inaccessible from any distant incision; and, further, if it became necessary to form an artificial anus, it would be a convenient point.

I had decided that if it should prove to be a recontraction of the stricture, to make a longitudinal incision about two inches in length carried through the ileum, ileo-cæcal valve, and cæcum, bringing the two ends of the wound together and sewing it up transversely; this would best be made on what would be the under surface of the bowel when the patient stands erect. I tried this on the cadaver and found it practicable, and that it increased the circumference of the bowel, at that point, about two inches. The head of the colon was readily found, there was no return of the intussusception, no adhesions had formed, though in reducing the intestine at the first operation there had been slight bleeding at a number of points at which adhesions were torn. The scar of the original intestinal incision was scarcely perceptible. At the ileo-cæcal valve, however, there was now a decided tumor, and it was now evidently epitheliomatous. An incision was carried into the mass and verified the diagnosis. The entire valve had become an irregular mass of epitheliomatous tissue varying in thickness from a half an inch to an inch, entirely obstructing the gut except an aperture in the centre, about one-third of an inch in diameter. The circumference of the valve was less thickened by the disease than the centre. The abdominal wound was now closed by sponges, leaving the diseased parts outside; three inches of the bowel, including the disease, were removed; no clamps were used, the bowels being held in the hands of an assistant; a few vessels were tied.

As the mortality is very high when the separated ends of the bowel, in these operations, are sewed together and returned, I had decided if it became necessary to excise, to establish a temporary artificial anus and begin at once the proceedings for its cure. With this end in view, immediately after the removal of the diseased bowel and the ligation of the bleeding vessels, one blade of Dupuytren's enterotome was introduced into each portion of bowel, viz., one into the ileum and one into the colon, the two blades were brought together and the screw run down firmly. A strong ligature was placed on the ends of the bowel, including the enterotome, to prevent the escape of feces during the subsequent manipulations. The bowel was washed, placed in position at the lower angle of the wound and fastened there with a continuous silk suture. The abdominal wound was closed, covered with cheese cloth saturated with mercurial solution, and this in turn with patent lint soaked in sweet oil. This is the best method that I have

found to protect abdominal wounds close to an artificial anus. The heavy ligature around the ends of the bowel was now removed. A ring of cotton soaked in oil was placed around the artificial anus, the outer extremity of the enterotome supported by oakum, and a wide bandage pinned over it. Morphine was used hypodermically during the first forty-eight hours and then discontinued; vomiting occurred during the first two days and then ceased. Some feces appeared on the evening of the operation, and full quantities two days later. On the eighth day the enterotome was found loose, and was removed; its removal was preceded by a passage of feces from the natural outlet. The stitches were removed on the third and fourth days, and the wound supported by adhesive plaster. After the removal of the clamp the patient was permitted to rise, and all restrictions removed from her diet.

The bowels acted naturally for a few times, when all the feces came again from the artificial anus. The clamp was again applied on the 17th, and came away on the 28th. Its removal was again followed by a few natural passages. As these ceased in a few days the clamp was applied for the third time with a precisely similar result. As this had proved ineffectual, the method of Mr. Banks, of Liverpool, was used. A strong ligature was fastened to the middle of a heavy piece of rubber gas tubing about six inches in length; one end of the tube was passed into one bowel, the other end of the tube into the other bowel, the middle of the tube pressing against the spur. The position of the bowel in this case was such that the rubber tube was retained with difficulty. After trying it for ten days without success, I substituted the apparatus which I here show, consisting of two pieces of very heavy rubber gas tubing joined together like the letter **T**. The upper part of the **T** is about one and a half inches long, and presses directly against the spur; the other tube is three inches long, and merely serves to keep the first in position. The large base is circular, is three inches in diameter, and serves as a pad to prevent the escape of feces from the artificial anus. The three pieces of rubber are joined firmly by a strong wire running from the first to the last piece, and twisted tight. This method proved at once satisfactory, and a large proportion of the feces began at once to pass by the natural outlet, and continued to do so. The patient is now in the hospital, but I shall make no attempt to close the fistula until it is seen if the bowels will continue to act naturally.

During this prolonged treatment, fearing that the colon, from disuse, might contract, I directed that she should be given an injection of a quart of water daily, and I was surprised to hear that when a pint had been given it appeared at the artificial anus. By continuing these injections the capacity of the colon was rapidly increased, and when last tried it held three pints; of course, when the bowels began to act naturally this was discontinued."

"*Case XIV.—Chronic obstruction of bowels by encephaloid tumor. Exploratory laparotomy; artificial anus established; recovery from the operation; death fourteen days later from obstructive peritonitis arising from tumor.*—Francis O. B., aged thirty-eight years, Irish, carpet porter, a patient of Dr. James Robinson, with whom I saw him January 18, 1888. He was in perfect health until June, 1887, when he began to have slight cramps, once or twice daily, and occasionally at night, in the left iliac fossa. He continued working until December 24, 1887, and has been confined to bed since. His attacks had not increased greatly in severity, but he was getting much weaker. He had lost fifty pounds in weight; he vomited once or twice a week; it was not stercoraceous. He suffered greatly with tenesmus, which produced from ten to fifteen passages during the night, each being a small, hard, white mass about the size of a cherry.

The left iliac fossa was slightly tender. The abdomen was distended with gas. The pulse was 104, and the temperature normal. His pain was uninfluenced by food. He had never passed blood by the bowel. The rectum was found empty and unobstructed.

Later I removed him to Jefferson Medical College Hospital, by which time his pain was nearly constant, and he was unable to sleep without large doses of morphine. Some days after admission his temperature increased to 103°; there was increased abdominal tenderness and other evidences of a slight attack of peritonitis, which disappeared in forty-eight hours. On the 28th he passed wind by the penis, and again on the 30th.

On January 30, 1888, with the assistance of Drs. Allis, Nancrede, Robinson, and the house staff, I opened the abdomen. A median incision about four inches in length was made, and a lobulated tumor the size of an orange was found in the angle between the bladder and the spine. The sigmoid flexure of the colon was tightly adherent to and partly buried in the tumor. The cæcum was carried toward the median line, and was also adherent to the tumor. The lower end of

the ileum was closely adherent, and its calibre nearly obliterated.

The colon was contracted and collapsed; all the bowels above the point of obstruction in the ileum were greatly distended.

As nothing could be done with the growth, a fold of the ileum a few inches above the point of obstruction was brought out of the wound and fastened in its lower angle by a few silk sutures; a rubber drain was introduced, as a glass one failed to reach the desired point, and the abdomen closed. The drain was removed about twelve hours later, as I feared to have it remain in such close proximity to the artificial anus. Twenty-four hours after the operation the fold of bowel in the wound was opened, and the artificial anus established.

On the second day the patient was placed upon his usual food, stimulants, etc. The stitches were removed on the fourth and fifth days; the wound healed promptly. It was successfully kept from contamination by the fecal discharges, by the method described in a case reported above.

At the operation a fold of bowel was brought entirely out of the wound; this was adopted as a modification of the method of entirely cutting off the bowel, closing the lower end with sutures, and using the upper to form the artificial anus.

The method here adopted has the advantage of rapidity, less danger of contaminating the cavity with fecal matter, as the opening of the bowel may be postponed until firm adhesions have formed. It permits any gases or other material that may be imprisoned in the lower bowel to escape, and quite as effectually prevents any material passing the artificial anus into the lower bowel.

The patient was relieved of his pain, the vomiting ceased, and he slept well; had a fair appetite, and improved in appearance. All fecal discharges, and they were very copious, came from the artificial anus, and none by the natural outlet after the first twenty-four hours.

On the thirteenth day there was a slight elevation of temperature, and all fecal discharges suddenly ceased; injections of warm water carried some distance above the opening by a soft catheter were without effect; by evening vomiting and other symptoms of acute obstruction occurred, and he died twenty-four hours later, or fourteen days after the operation.

The *post-mortem* examination was made on the same day. The abdominal wound was solidly healed; the bowel, at the artificial anus, was firmly attached to the abdom-

inal opening. The abdominal cavity contained quite a quantity of opaque serum; the opacity was greatest near the tumor, and on pressing the tumor, thick, purulent-looking fluid exuded from it. This was probably the origin of the fatal peritonitis. The bowels were but slightly congested, and only at one point, about twelve inches above the artificial anus, were adherent. The bowel at this point was sharply flexed upon itself, and adherent for about three inches, causing complete obstruction. This adhesion was readily broken down by the finger, and it would probably have yielded to an active saline.

The condition of the bowels, as found at the time of the operation, was verified; the tumor was broken down, and had ulcerated into the sigmoid flexure; a large number of secondary nodules were scattered through the liver. The microscopical examination was made by Dr. Longstreth; the tumor and the nodules from the liver were reported by him to be encephaloid.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, April 23, 1888.

The President, LAURENCE JOHNSON, M.D., in the Chair.

After the passage of resolutions concerning the death of Dr. C. R. Agnew, the scientific paper of the evening was read by DR. W. C. JARVIS, entitled,

The Indications for the Surgical Treatment of the Deflected Nasal Septum, with an Analysis of One Hundred Cases.

There were, the author said, definite symptoms and pathological complications easily recognized and explained as being more or less directly associated with deflected nasal septum, and which afforded excellent guides in the treatment of this complaint. Such guides, however, had not been pointed out in any single paper, and it was to supply this want that he addressed the Society.

His cases included only those which had been treated in private practice and of which he had kept the detailed history. In forty-two of the cases the deflection of the septum was to the right, and in forty-seven to the left, while in eleven it was bilateral. Seventy-eight were purely cartilaginous, seventeen were osseo-cartilaginous, five were osseous deflections.

The principal indication for surgical interference was nasal stenosis, which was present in eighty-one of the cases. Among the most

important complications which should be recognized from the start as special indications for an operation were hypertrophies of the turbinated bones. These were present in twenty-four per cent. of the cases of deflection to the right, in eight of which an operation was required to remove the redundant tissue; and in twenty per cent. of the deflections to the left, requiring operative interference in four cases. Posterior hypertrophies were present in fourteen per cent. of the cases. Slight redundancies of the turbinated tissue which were present in all cases of deflected septum were not considered. The next most common complication was trouble with the ear, it being present in twenty-nine cases. In some the operation was undertaken for the relief of this alone. The bulk of these were in physicians who recognized the necessity for perfect ear ventilation.

The eye was complicated in a marked manner in eleven cases. Well marked catarrhal headache was present in fifteen cases. Other complications were hay fever, polypi, bronchitis, etc. Hypertrophic rhinitis was present in ninety-four cases; atrophic rhinitis in six.

The stenosis which was so common was in some cases complete, while in others it was incomplete, or alternated from complete to partial. Snoring was common, and while this might occur without stenosis, it was frequently caused by stenosis, and might in persons of delicate health be of serious import. Nasal stenosis was capable of producing pharyngitis, laryngitis and bronchitis. Dr. Jarvis thought it might, under favoring conditions, induce phthisis. It is sometimes caused by a dam-like accumulation of the fluids in the nose, and made an operation necessary to open up the nasal gutters. Some patients had been operated upon unnecessarily, an acute congestion of the turbinated tissues having been mistaken as a symptom of septal deflection. The diagnosis could be made by the lapse of time, use of cocaine and the rhinometer.

Conditions in which an operation was not indicated were named as follows: 1. Extra nasal deflections. 2. Cases in which the septum was deflected, but so far forward as not to interfere with the rise and fall of the turbinated tissue. 3. Deflected non-obstructive septa. 4. Non-obstructive deviations in the nostril exhibiting a pale or normal hue of the pituitary membrane. 5. Slight localized non-obstructive bending of the vomer placed above the level of the nasal floor and occupying the more spacious portion of the nostril. 6. Cases of considerable deflection,

non-obstructive, presenting a smooth regular surface and gentle undulation.

In twenty-four per cent. of the cases the snare alone was employed, in twenty-nine per cent. he used the septum scissors, in eleven, the fracture forceps; in six, the surgical drill, and in thirty the electrical drill.

DR. BUCKLIN thought we could not form an opinion as to the amount of space required in the nostril for breathing purposes by a comparison with the size of the lumen of the tube used in laryngeal intubation. There should be room for free play of the mucous membrane covering the turbinated bones, which varied with the temperature in different individuals. He thought nasal stenosis required especial attention as it so frequently led to catarrhal deafness. In the class of cases under discussion there resulted changes in the connective tissue in the nose, attended by the secretion of tenacious mucus. This would not cease immediately after removal of the deflection of the septum, overcoming the stenosis, and for that reason patients had often regarded the treatment as a failure in not overcoming the chief symptom from which they had suffered. He had a patient whose commencing phthisical symptoms disappeared at once after overcoming the stenosis.

DR. CLARENCE RICE regarded surgical interference performed gently and by a careful operator as less heroic treatment than the use of swabs and douches so commonly resorted to a few years ago, and still much employed by many who condemned surgical interference.

DR. PHILLIPS thought the indications for treatment were to enable the person to breathe freely through the nostrils. After an operation the treatment of the wound was of special importance to avoid adhesion of opposing surfaces.

DR. TANSLEY had in a number of instances had occasion to treat patients for a suppurative otitis which had been excited by operations upon the nose in patients whose auditory difficulty had not been of an active kind.

DR. BEVERLEY ROBINSON favored the use of caustics and the cautery.

—Dr. S. G. Dixon suggests in the *Therapeutic Gazette*, April, 1888, that the usual model of suppositories for the rectum be so changed as to make the present base a short cone. When the suppository is introduced by this short cone beyond the internal sphincter, the contraction of this muscle upon the longer cone will force the entire suppository further up the bowel.

HOSPITAL NOTES.

THE TREATMENT OF PUERPERAL SEPTICÆMIA AT THE PHILADELPHIA LYING-IN-CHARITY— WITH REMARKS.

CHARLES P. NOBLE, M.D.,
SENIOR ASSISTANT PHYSICIAN.

The treatment is based upon the principle that puerperal septicæmia is caused by the entrance into the system of an infectious material through lesions in the genital passages. This infectious material is believed to be certain micro-organisms, which produce their effects either directly by their action on the fluids and tissues of the body, or indirectly through certain products of their activity, called ptomaines, or both.

The prime object of local treatment in puerperal septicæmia is to render and maintain the utero-vaginal canal in an aseptic condition. It must be recognized, however, that when once the germs are within the tissues or vessels of the puerpera, they are beyond the influence of local medication. Hence the result to be hoped from local antiseptics is that it will limit the dose of poison to that which has been absorbed before treatment was instituted. The tissues and white blood cells must be left to battle with those germs which are already within the tissues, assisted by constitutional medication. Therefore the results from local treatment are most brilliant in cases of putrid infection, where the fever is due rather to the absorption of the products of decomposition of the lochia, or of fragments of retained placenta or membranes, than to the action of germs on the tissues of the patient.

Other objects to be gained by local treatment are to favor the healing of wounds, and promote the comfort of the patient.

Neither septic abscesses of the pelvic cellular tissue nor pyæmic abscesses have developed in the Charity's cases (within three years), nor has phlegmasia dolens been observed. In two cases gonorrhœal salpingitis has developed in *puerperio*. In one—an out-patient—peritonitis succeeded, laparotomy was done by Dr. Longaker, the diseased tube removed, and irrigation practiced. The patient was *in extremis* before the operation, and died shortly afterward. In one case an old pyo-salpinx induced purulent peritonitis and death, without operation. These cases are mentioned to show the variety of conditions usually classed as "puerperal fever."

Where a diagnosis of puerperal sepsis is made, local irrigation is instituted at once, irrespective of the odor of the lochia. Where the temperature does not exceed 102° F., vaginal irrigation alone is practiced. This is for the reason that infection takes place in the majority of cases through lesions of the vagina or vulva, and only exceptionally from within the uterus. Corrosive sublimate solution (1-2000 to 1-4000) is used. The irrigations are repeated at intervals of three or four hours by the nurse. Where the fever does not subside in from six to eight hours, or increases, the uterus is washed out by the physician himself. This necessitates a digital examination, when bits of placenta or membrane, if present, are removed by the finger. The dull curette has been used to some extent, both for diagnosis and the removal of foreign material from the uterine cavity, and is regarded with favor. But no mere instrument can give the information derived through the sentient examining finger; nor will any inflict so little traumatism in the removal of foreign bodies. The uterine cavity is examined only after vaginal irrigation, lest having previously escaped, it be infected by the septic vaginal discharges carried on the finger. The modified Bozeman canula is used. A hundred grain iodoform pencil is left in the uterus. This slowly disintegrates and is present in the discharges for two or three days. After this thorough disinfection, the fever, especially if due to putrid absorptions usually disappears. Otherwise vaginal irrigation is continued as before; and should new chills occur, or high temperature continue (above 103° or 104° F.), the uterus is again washed out and the iodoform pencil left in as before. The woman need not be disturbed during the manipulations. The vaginal irrigation is discharged in a bed-pan, then the canula is introduced within the uterus along the finger, as a guide. All air is previously expelled and the stream allowed to run during the introduction. Irrigation is continued until the stream returns clear—from one to three pints are necessary. After removing the canula the uterus is grasped and made to expel all fluid, and the perineum slightly retracted to insure its discharge from the vagina. Dr. Wilson sometimes irrigates through a speculum. No case of serious mercurial absorption has occurred. Salivation was induced in one case. No case of iodoform poisoning has been seen. Not infrequently after the intra-uterine douche, and quite commonly after the removal of more or less putrid material from the uterus, a chill and rise of temperature results, which soon subsides. This

is partly due to nervous shock and partly to the temporarily increased absorption of poisonous material, caused by abrasions produced during the manipulations of the finger, curette or irrigator.

In those unfortunate cases in which fever continues in spite of treatment, it becomes a question, after several days, whether irrigation is of further value. Feter of the lochia is a constant indication, but it is not apt to be present after the removal of foreign matter and thorough utero-vaginal disinfection. In the presence of marked parametritis, without special indications to the contrary, the vagina alone should be douched.

On one case diphtheritic patches occurred on the fourchette. They were treated by the application of pure carbolic acid followed by iodoform.

Turpentine stupes, and at times poultices, are used in cases of metritis or peritonitis, with tenderness on pressure, and tympany.

Constitutional treatment, while considered in the majority of cases of secondary importance to local measures, is by no means neglected. Nor is it forgotten that in the cases in which marked invasion of the tissues and vessels by germs has taken place (before local antisepsis could cut off the supply), it is the only means of favoring a successful issue. The indications are to support the strength, combat hyperpyrexia, and meet special complications and symptoms. It is a problem of "the survival of the fittest" between the host and the invading germs.

Proper alimentation is of the highest importance, especially in protracted cases. Milk, given in quantities that can be assimilated, is largely depended upon. In irritable stomach lime water or whiskey is added. Beef tea, nutritious broths, and the various nitrogenous prepared foods are used as adjuvants, or where milk disagrees. Quinine in divided doses, not exceeding fifteen grains daily, is believed to conserve the strength. Whiskey is given as indicated. Most cases at all protracted, require it early, and can take it in large amounts. The first sound of the heart is the most reliable criterion by which to be guided in its administration. Brandy is at times substituted, and champagne is used where troublesome and otherwise uncontrollable nausea is present. The administration of spirits is considered of great value in combating septic fever.

Hyperpyrexia (approaching 104° F.), unless transient, is met by antipyrin (grs. xv to xx) repeated every hour or second hour, until the temperature falls below 102° F. The pulse is always watched during its

administration, and stimulants given if necessary. In two cases, which subsequently recovered, collapse occurred after the administration of two fifteen grain doses of antipyrin at intervals of an hour, the temperature falling to 97° F. Quinine in fractional doses is substituted when the temperature is below 102° F., being used principally for its tonic effect. The cold coil has been used in a few cases.

Opium is largely relied upon to allay restlessness, induce sleep, and relieve pain. Pain is very seldom complained of; tenderness on pressure is usually its greatest manifestation.

In the few cases in which peritonitis has been present, turpentine by the mouth and by enema has been used to relieve flatus. The question of opium *versus* saline purgatives is under consideration, but it is by no means considered advisable to prevent an occasional movement of the bowels.

For weak heart, while digitalis is used, more is expected from alcohol and alimentation. Ergot is believed to be of use in preventing septic absorption, not only by favoring an empty and contracted uterus when used *post-partum*, but also, perhaps, by its action on the muscular tissue of the utero-vaginal canal and absorbents, in the presence of septic material.

Other special complications and symptoms when present, are treated on general therapeutic principles.

SPECIAL CORRESPONDENCE.

THE DAY BEFORE THE ASSOCIATION MEETS.

CINCINNATI, May 7, 1888.

The day before the opening of the meeting of the American Medical Association is usually characterized by the gathering of a large portion of the members. Some of them come early so as to avoid the crowding and inconveniences of the first day, and some to meet their friends and talk over matters in which they feel especial concern, before the time for action arrives. In this respect the present occasion does not differ from its predecessors. The hotel corridors are thronged with active and earnest-looking men. Everywhere clusters of chairs are drawn up and men lean over toward each other as they talk and listen; and it is clear that the business of the Association is being discussed, and perhaps, arranged by those who make up the groups.

At this moment two questions are being actively discussed. The first is, who shall be the next President of the Association? The second is, where shall the next meeting be held? In regard to the presidency, three names are being canvassed: those of Dr. Moore, of Rochester, of Dr. Dawson, of Cincinnati, and of Dr. Matthews, of Louisville. Each name is supported by warm friends.

Dr. Moore and Dr. Dawson are urged for the office on the ground of their age and standing in the profession, and the fact that they are men whom the Association may appropriately honor with this distinction. The name of Dr. Matthews is being advocated chiefly on the ground that he is young, energetic, a good parliamentarian, and likely to be able to maintain order and discipline in the business meetings of the Association. Some recent experiences have convinced a number of the members of the Association that the body needs for the Presidency a man who adds to a high professional standing, familiarity with parliamentary rules and customs, and a quick and firm judgment. How far this opinion may go in the present canvass, it is now impossible to say; but there can be no doubt that it has much in its favor. The outlook now seems to be favorable to the election of Dr. Moore or Dr. Dawson.

At the meeting of the

American Association of Medical Editors,

held this evening, a permanent organization was effected by the adoption of a few articles of constitution. There was a large number of editors present, and an animated discussion took place in regard to the effect, upon medical journalism and the profession, of so-called "trade-journals." The general opinion was that they are of disadvantage to the members of the profession, as well as injurious to regular medical journals. This view was opposed by a gentleman—not a member of the Editors' Association—who was invited to speak on the subject. One of the editors expressed the opinion that there is no use in discussing this question, except as the discussion may lead to better work by the editors and publishers of medical journals; since the only practicable way to compete with the inducements offered by the manufacturing houses which issue journals of their own, is to offer the profession better journals at a reasonable price.

Among the men who are already here, there are many whom it would be a pleasure to name; conspicuous among them are Dr. Garnett, of Washington, the President of

this year; Dr. N. S. Davis, of Chicago; Dr. Garcelon, of Maine, and Dr. Henry H. Smith, of Philadelphia. These are the principle points which were impressed upon me during the day before the meeting of the Association.

On the first day of the meeting, May 8, a large number of delegates and members gathered in the Music Hall, and the meeting was formally called to order by Dr. Dawson, and opened with prayer by Rev. R. A. Gibson. After which, an

Address of Welcome

was delivered by Hon. Amor Smith, the Mayor of Cincinnati. In this address the mayor extended to the members of the Association a hearty welcome to the city. The address was excellent and sensibly brief, and contained amusing allusion to the time, twenty-five years ago, when the then mayor of Cincinnati thought it worth while to issue an order to the police, that for the time they should not be too strict with exhilarated midnight strollers, lest they should by mistake offer an affront to some rejoicing and belated member of the American Medical Association, which was then, as now, the guest of the city.

This order, Mayor Smith said, he would not now issue, lest he should seem to forget that since twenty-five years ago there were women who had entered the portals of the practice of medicine, and even of the American Medical Association, but he assured the members of the Association that everything in his power would be done to make their visit to Cincinnati both pleasant and enjoyable.

Dr. C. G. Comegys followed, on behalf of the Medical Profession of Cincinnati, in another address of welcome. In this, he gave an interesting sketch of the history of that part of the Ohio Valley in which Cincinnati is situated. He portrayed the settlement of this region, its vicissitudes of Indian wars and final deliverance from danger, and the development of its material and intellectual welfare.

Dr. Garnett's Presidential Address followed, and proved to be an able argument in favor of elevating the standard of medical education in this country, favoring a compulsory four years' graded course, a State examination for a license to practice, and cancelling the charters of schools which failed to show a class of at least fifty students for any period of five consecutive years. The address was received with marked manifestations of approval, and made an obvious impression upon the audience.

After some miscellaneous business had been transacted, the general meeting adjourned for the day.

In the afternoon the various sections met in the numerous and convenient rooms of the Music Hall, being well attended in spite of very changeable and threatening weather.

The reception of the Association by the medical profession of Cincinnati is most hearty, and the arrangements made for its accommodation, both scientific and social, are admirable. The members of the Association seem to be generally animated by a spirit of concord and fraternity.

The place of meeting next year will probably be either Philadelphia or Baltimore—most likely the former.

Yours truly.

J. C. B.

PERISCOPE.

Apparatus for Removal of Pleuritic Effusion.

In the *Berliner klinische Wochenschrift*, March 26, 1888, Prof. Fürbringer, of Berlin, describes an ingenious and simple apparatus for the aspiration of serous effusions in the cavity of the pleura.

This apparatus, of which we give an illustration, is composed of a receiving-bottle



of about one quart capacity, with a rubber stopper, through which pass the ends of two glass tubes, bent at a right angle, and fitting hermetically. One of these tubes goes nearly to the bottom of the vessel; the other passes only through the stopper. The former is connected with a rubber tube, fitting over a canula three or four millimeters in

diameter, and supplied with a stop-cock; the latter is connected with another rubber tube supplied with a compression-stop. In using the apparatus, the end of the second tube is placed in the mouth of the operator and about three fluid ounces of a warm one to two per cent. solution of boric acid is sucked into the bottle through the other tube. The canula is then thrust with the aid of a trochar into the pleural cavity, the trochar withdrawn, the stop-cock closed, and the tube attached. The operator now sucks a little upon his tube and closes it; then the stop-cock in the canula is opened and the fluid begins to flow into the bottle. As soon as the effusion reaches the fluid in the bottle, the compression of the operator's tube is removed and the effusion will continue to pass into the vessels so long as there is any pressure upon it within the chest. When it ceases to flow spontaneously, its flow may be solicited by suction upon the operator's tube. In this way about a quart of fluid can be removed from the chest without any risk to the patient or inconvenience to the operator. If the quantity to be removed at one sitting is more than a quart, the canula can be closed, the bottle disconnected and emptied, new antiseptic fluid poured into it, the patient's tube re-connected to the canula and the subsequent steps of the preceding procedure repeated. The method described provides for the slow evacuation of a pleuritic effusion in the most gentle and satisfactory way. It has been used by Fürbringer in more than fifty cases without accident or inconvenience, and certainly deserves to be brought to the attention of American physicians.

Hydrastis Canadensis.

In a clinical and pharmaceutical study of the root by Givopiszew (*Thèse*, St. Petersburg, *Bulletin général de Thérap.*, Feb. 29, 1888), the writer presents the following results, which, so he states, are "based upon a large number of clinical observations and experiments upon animals:" 1. The aqueous extract, even in large quantities, did not produce toxic effects in warm-blooded animals. 2. It always caused a diminution of blood pressure without a previous augmentation. 3. It always induced contraction of the uterus and its appendages. Under the influence of an aqueous extract of hydrastis the most intense contractions took place in cases of advanced pregnancy, or soon after delivery; the contractions were weakest in the virgin uterus. 4. Large quantities of the extract may induce premature delivery in the second

period of pregnancy. As clinical results, the author concludes: 1. Hydrastis is an excellent agent to combat uterine hemorrhages due to inflammation or false positions of the organ, as also against hemorrhages following the catamenial period, and in the case of too abundant menstrual losses. 2. Uterine contractions produced by hydrastis are less intense than those from ergot of rye. 3. Its use produces no untoward effect upon the organism. Even when taken for a prolonged period it causes no gastro-intestinal troubles, and often ameliorates dyspepsias which have previously existed.—*Amer. Journal of Pharmacy*, April, 1888.

Prevention of Syphilis.

The Paris correspondent of the *Medical Press and Circular*, February 15, 1888, states that M. Fournier has presented to the Academy of Medicine the report of the Committee appointed to inquire into the best means of preventing the spread of syphilis. The following are the principle articles: 1. The Academy calls the attention of the authorities to the development to which prostitution on the streets has grown, and demands that energetic means be taken to repress it. 2. The legion of wine-shops only assist clandestine prostitution and should be suppressed. 3. A strong and active surveillance should be exercised in the neighborhood of the colleges, where temptation is rife. 4. A girl proved to be contaminated should be sent to a special sanitary hospital, from which she should not be discharged without being furnished with a medical certificate; at the same time the rules of the hospital should have in nowise the stringent character of the present St. Lazare. 5. The registered women should be visited regularly once a week and once a month by a medical inspector. 6. Instead of increasing the number of beds in certain hospitals in which venereal diseases are treated, new special hospitals should be created outside the walls of Paris, to which free dispensaries should be attached. 7. Every student of three years' standing should have free access to all these institutions, and before presenting his thesis he must produce a certificate justifying a three months' stage in one of these services.

—An engine-fitter residing near Bolton, England, recently died from the effects of drinking an infusion of one ounce of colchicum seeds and a drachm each of iodide of potassium, slippery-elm, and guaiacum, the ingredients having been sold to him by a local herbalist.

Epithelioma of Penis and Scrotum; Complete Removal of External Genitals; No Recurrence at the end of Six Years.

F. A. Southam, assistant surgeon to the Manchester Royal Infirmary, reports the following case: John T., 55 years old, was admitted into the hospital in June, 1881, suffering from well-marked epitheliomatous ulceration of the penis. About twelve months previously the right testis had been removed for what had been regarded as "strumous disease," otherwise he had always enjoyed good health, and there was no history of syphilis. Amputation of the penis was performed, and the patient left the hospital at the end of the month, with the wound not quite healed. Between two and three months subsequently he returned with a recurrence of the ulceration, which presented all the appearances of epithelioma, in the stump of the penis and scrotum; the latter was somewhat extensively involved, a sinus leading down to the left testis, which from implication in the disease had become adherent to the scrotal tissues; the inguinal glands, though slightly enlarged and tender, appeared to be free from any secondary deposits.

In August, 1881, the stump of the penis, the remaining testis, and almost the whole of the scrotum were removed by two elliptical incisions carried wide of the disease, just sufficient integument being left on either side to meet in the middle line and cover over the extensive wound. The urethra and corpus spongiosum, which had been divided far back, were dissected out, turned downwards, and attached by sutures to the skin at the lower angle of the wound.

The patient made a good recovery, and left the hospital at the end of September. The wound had almost healed, and he was able to pass his urine very freely through the perineal opening. He attended as an outpatient during the next few months, and was then lost sight of. Nothing more was seen or heard of him until September, 1887, when, after an interval of six years since the operation, he came to the hospital to show that he was still alive and well. He stated that he had enjoyed good health since last seen, and had never experienced any difficulty with his urine. The perineal opening, which had not shown any tendency to contract, was large enough to admit a No. 10 catheter, and the urine was passed in a very good stream. He was quite free from any evidence of recurrence of the disease,

either in the cicatrix or lymphatic glands in the groin.

The author remarks that the successful result in this case must be attributed to the fact that at the second operation the parts were removed wide of the disease, and that the lymphatic glands had not become the seat of any secondary deposits. Inasmuch as six years have now elapsed since its performance, the cure may be regarded as permanent and complete.—*Medical Chronicle*, March, 1888.

Case of Myxœdema.

At the meeting of the Medico-Chirurgical Society of Sheffield, January 19, Mr. W. Makeig Jones presented a case of myxœdema in a married woman, 50 years old, which had been gradually coming on for the last four or five years. About two years ago slowness of speech and general swelling of the skin was noticed. The symptoms were: Great anæmia, with limited rosy patches on both cheeks, centre of forehead and lips. Firm elastic swelling, not pitting on pressure, of the whole cutaneous surface, and also of the mucous membrane of mouth and throat. Commencing atrophy of both optic discs. Pupils sensitive to light. Characteristic thickening of skin over anterior triangle of neck. The thyroid gland, especially the left lobe, larger than in women of the same age. Systolic basic bruit. Exaggerated patellar reflex. Characteristic spade-like hands. Urine about one pint in twenty-four hours; pale, sp. gr. 1014—1020, full of phosphates, but not albuminous (it contained albumin eighteen months before). Temperature in mouth 96°. Pulse 48—60. General lethargy, slowness of speech, and stammering (she could, however, read fluently), slowness of movement, sensation and intellect. Unpleasant taste, but not smell.—*Medical Press and Circular*, February 8, 1888.

Laparotomy for Intestinal Obstruction Due to Gall-Stone.

We learn, says the *Lancet*, Feb. 11, 1888, that Mr. Charles Stonham has recently performed laparotomy in a case of intestinal obstruction, and found a gall-stone firmly impacted in the ileum, about twenty inches above the ileo-cæcal valve. The stone was removed by a longitudinal incision about one inch in length, and the wound closed with a double row of fine silk sutures. There was recent peritonitis of the gut above the stone, but none below. The patient, a woman, 66 years old, died fifteen hours later. Symptoms of obstruction had lasted forty-eight hours.

Experience in the Use of Cocaine.

Dr. Edmunds says that on applying cocaine subcutaneously for the production of local anæsthesia, it is not advisable to use a stronger solution than five per cent. In his earlier cases, in which this strength was used, constitutional symptoms were never seen; but when, owing to the anæsthesia in one case not being sufficient, he used stronger solutions, there occasionally occurred one or more of the following symptoms: pulse becoming very rapid, weak, and almost imperceptible; sense of faintness and feeling of distress in the region of the heart, blueness of lips, cold perspirations, restlessness, amounting almost to convulsive movements, and dilated pupils. Happily these symptoms never lasted very long; but as nothing of this sort was seen with a five per cent. solution, it seems better not to go beyond that strength.

Cocaine will entirely prevent the pain of the injection of tincture of iodine into the tunica vaginalis for the cure of hydrocele. In two cases a solution of five grains of cocaine in fifty minims of water, was injected through the canula after the fluid had been drawn off. When, after the lapse of five minutes, tincture of iodine was injected, there was no pain or feeling of faintness, nor were there any constitutional symptoms from the cocaine. The iodine and the iodide of potassium in the tincture of iodine react with the cocaine chemically, but these changes do not prevent the cure of the hydrocele. It is true that the injection of a saturated solution of carbolic acid in glycerine into a hydrocele sac does not cause pain; but this treatment is apt to fail.—*Lancet*, January 7, 1888.

Pulmonary Endarteritis.

At a meeting of the Pathological Society of London, February 21, 1888, Dr. G. F. Crooke showed specimens from a case of pulmonary endarteritis. The patient had complained of shortness of breath, pains in the left side and back, pain and fulness in the abdomen, and swelling of the legs. At the necropsy there was found stenosis of the mitral valve, probably congenital, hypertrophy of the left auricle, great hypertrophy of the right ventricle, and dilatation of the pulmonary artery. The smaller branches of the latter vessel showed great thickening of the intima, which was roughened and nodose, and was undergoing fatty changes. The smallest twigs showed marked obliterative endarteritis, and contained small adherent thrombi. There was no systemic atheroma.—*Lancet*, February 25, 1888.

Transudation and the Influence of the Blood-pressure upon the Behavior of Transudates.

Prof. H. Senator, of Berlin, concludes an article in *Virchow's Archiv*, Bd. cxi, Heft 2, Feb. 1888, with the following statements:

All transudates, without exception, contain albumin in solution, but in a smaller quantity than the blood-plasma. The quantity of albumin is smallest in normal transudates and in œdema of the skin. The albumins of the transudate are the same as those of the blood-plasma, namely, serum albumin, serum globulin and fibrinogen. Concerning their ratio to one another and to the quantity present in blood-plasma, little is known. The quantity of saline constituents in the transudate is pretty nearly the same as that in the blood-plasma, but varies slightly. Not rarely it surpasses that of the blood-plasma in the same person. All transudates contain such other non-colloid bodies as are in solution in the blood, bodies which never pass out in pure glandular secretions, such as biliary coloring matter and hæmoglobin. Substances not preformed in the blood are not found in any transudate, unless the latter has become decomposed. Tissues which produce transudates lack the specific powers of gland cells. Filtration experiments performed outside the living body are not decisive with regard to the influence of blood-pressure upon transudation. Rise in venous pressure effects increase of the quantity of the transudate and of its contained albumins, while the amount of its saline constituents is not materially changed. Rise in arterial pressure (*i. e.*, active hyperæmia) appears in the same manner to increase transudation. Nothing definite is known concerning the quantity of albumin in transudates occurring in simple arterial hyperæmia. Section of the sympathetic nerve seems to increase the quantity of albumin in the area of transudation. The quantity of saline constituents in the transudate is not materially changed in arterial hyperæmia.

—A plan for an enlargement of the Pennsylvania Hospital has been proposed, which will more than double the capacity of the hospital, and at the same time leave sufficient grounds around the building to make them attractive for convalescents. It is said that at the meeting next month a plan will be considered for a building fronting on Spruce street, with suitable annexes for the accommodation of physician, surgeons and nurses

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CHARLES W. DULLES, M. D., EDITOR.

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AN IMPORTANT STEP IN VACCINATION.

In these days of antiseptic surgery, when it is believed that the most serious consequences may follow the introduction into the human system of germs which are constantly present in the air and on the surface of the body, it is a somewhat singular spectacle to see men who are full believers in the germ theory habitually doing a thing which according to this theory must be exceedingly dangerous. We refer to the practice of vaccination as it is ordinarily carried out. In this procedure a portion of the skin is scratched until the corium is reached, and then a portion of vaccine virus is thoroughly rubbed into it with the aid of sufficient moisture. It is the misfortune of physicians and patients that there is no practicable way of securing supplies of vaccine virus which will insure its entire freedom from the germs of erysipelas or some other disease; and, no matter how careful and conscientious the vaccinator may be, he may inoculate his patient with something very different from what he intended.

But there is another source of danger to the patient which does not depend upon the nature of the virus used, and which may have its share in producing the violent inflamed sores and profound constitutional disturbance which too often follows vaccination. This source of danger lies on the skin of the patient, in the shape of dead epithelium, which may have undergone some decomposition from the action of the perspiration, or of morbid organisms which have been deposited in it.

We believe this source of danger in vaccination has not received the attention it deserves, and that it would be profitable for some investigator to try to learn what proportion of bad arms are the consequence of the failure of physicians to render aseptic that portion of the skin of their patients which they select as the place for vaccination.

Meanwhile we would urge upon our readers the desirability of making it an invariable rule to thoroughly cleanse the site of vaccination with water and soap—and perhaps some antiseptic—and brisk rubbing; so that, if a bad arm follows, they may feel that they have not neglected so simple a step, which is suggested by common-sense and made almost imperative by the accepted tenets of general surgery. To vaccinate an unwashed arm ought, we believe, to be regarded as an error in practice.

TREATMENT OF PENETRATING WOUNDS OF THE ABDOMEN.

At a recent meeting of the Société de Chirurgie, of Paris, M. Reclus brought up for discussion the subject of the treatment of penetrating wounds of the abdomen, and more especially of pistol-shot wounds. From a careful study of the subject, and from the result of a number of experiments on dogs, he has come to the conclusion that a considerable proportion of cases in which the intestine is penetrated by a small body will recover spontaneously, and that the statistics of laparotomy do not offer anything better to the surgeon than is shown by his own studies of the result of expectant treatment combined with physical and physiological rest.

This view is diametrically opposed to that which is now current in the surgical world, and especially in this country. So it is interesting to note that it has not been admitted without question even in France. The Paris Society of Surgery has followed the subject up in a discussion which engaged the voices of the best surgeons of that city. The general conclusion was altogether favorable to what is recognized as the "American" idea: that laparotomy should be performed boldly in cases of penetrating wounds of the abdomen, where there is any reason to suspect that the bowel has been penetrated. According to Trélat, the chances are ninety-seven in a hundred that the bowel is penetrated when the abdominal wall is; and the views of Reclus are not borne out by general surgical experience.

It is well known that penetration of the stomach is not so likely to be followed by serious peritonitis; and this fact may be borne in mind in determining the propriety of laparotomy in individual cases; but in general we believe the whole surgical world accepts the view which is called the "American" view, and is not prepared to abandon it upon the ground of such evidence as M. Reclus has brought forward, no matter how fully both he and it are deserving of respect.

CURIOUS BACTERIO-THERAPY.

A few medical men have been carried away by that singular product of latter-day cerebration: "bacterio-therapy;" and a very few have actually attempted to put it into practice and have "set a thief to catch a thief" by administering the bacteria of one morbid condition to counteract the effects of the bacteria of another. This curious idea has not had much following, however, and appears now to have died the death it deserved.

But a communication of M. Frémont to the Société de Biologie of Paris, at its meeting on April 7, 1888, seems to look in the same direction. M. Frémont reports that an examination of the waters of Vichy has disclosed to him the presence of different varieties of micro-organisms in the waters of different springs, and he believes this fact

accounts for the different medicinal properties of these waters, which he says are "almost" identical in chemical composition. It is hardly likely that M. Frémont has overlooked the fact that waters almost identical may produce different effects, for this reason alone; and the differences observed at Vichy must in his opinion be of a character which cannot be explained on a chemical basis. If this be the case, his appeal to the bacteria contained in it can be regarded only as an illustration of a sort of belief in bacterio-therapy. This is very curious; but it requires much further elucidation than M. Frémont has given it, before it can be accepted as of great scientific value. It would be interesting to have a full account of the character and numbers of the micro-organisms which he has found in Vichy water, and there ought to be little trouble in controlling his observations so as to determine whether there is something or nothing in his singular announcement.

CARE OF THE INSANE IN PENNSYLVANIA.

So long as insanity is one of the afflictions of the human race, one of the most interesting subjects of medical and humane thought must be how to provide for the helping and treatment of the unfortunate beings who suffer with it. The fifth Annual Report of the State Lunacy Commission of Pennsylvania shows that out of over nineteen thousand insane persons admitted to the five State Hospitals up to last year, more than seven thousand have been cured or improved sufficiently to be restored to their families. This admirable result indicates the great improvements which have been made of late in the care of the insane and in the treatment of mental diseases.

Part of the report referred to discusses the question whether or not State hospitals are better places for the care of the insane than county alms-houses. In regard to this matter the Commission is strongly of the opinion that State hospitals are much preferable to alms-houses. We have already, in the REPORTER, April 14, 1888, expressed our own conviction that this is the case; and are sure that a knowledge of what still occurs in the

alms-houses of such enlightened States as New York and Pennsylvania would convince the most skeptical that they are not places for persons whose care and treatment demand so much skill and patience. We hope the time will soon come when no insane person will be confined in any establishment which is not especially designed for this purpose, and governed by men who have special fitness for such a work.

KÜSTER'S OPERATION FOR HERNIA.

In the *Centralblatt für Chirurgie*, March 17, 1888, Prof. Küster calls attention anew to and advocates his method of operation for hernia. This method has been fully described a number of times. It consists in opening the sac in the usual way, restoring the bowel to the abdominal cavity, cutting off the sac, and stitching the edges carefully. After this the hernial opening is stitched, and the rest of the wound is closed by successive rows of continuous catgut suture, so that there is no space left for any accumulation of blood or serum between the cut surfaces. After the skin is sutured, the wound is painted with iodoform-collodion until no blood can come through the coating. After this no further dressing is applied.

Küster maintains that this method accomplishes all the objects of the usual antiseptic method, while it is much simpler than the latter. Its success depends largely upon the care with which the preliminary steps of the operation are carried out, and the strictly aseptic condition of the wound before it is sutured. Küster's opinion of its value is supported by the results he has obtained with it in thirty-three cases, in only two of which death followed the operation, and in neither of which was it attributable to the method.

Such a simple plan of treating the wound in herniotomy has much to recommend it on theoretical grounds, and is worthy of the attention of surgeons in this country, as well as in Europe.

VITA NUOVA.

The *Boston Journal of Health* continues its good work of exposing medical frauds by publishing a detailed description of an anal-

ysis of Harriet Hubbard Ayer's nostrum called "Vita Nuova." This is recommended—with abundant testimonials, of course—as a safe and sure cure for the alcohol habit. It is probably nothing but a native Port wine.

Our friends of the religious press may reflect upon this, when they sanction the insertion of advertisements containing the false statement that it is positively free from alcohol; and may ask themselves how they must appear to a profession which is not likely to judge such conduct too leniently when they lay themselves open to the accusation of taking money for promoting the schemes of designing and unprincipled adventurers.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE SKIN: A PRACTICAL TREATISE FOR STUDENTS AND PRACTITIONERS. Second edition, thoroughly revised and enlarged. By JAMES NEVINS HYDE, A.M., M.D., Professor of Skin and Venereal Diseases, Rush Medical College, Chicago, etc. Philadelphia: Lea Brothers & Co. Price, cloth \$4.50, sheep \$5.50.

The author in his preface to the second (present) edition states that the volume has been thoroughly revised, and much new matter added; and this statement is verified by almost every page. In fact, so thoroughly has the revision been made that the result is practically a new work. The numerous woodcuts, many of which are new, are, with few exceptions, good, and lend value to the book. The classification followed is that adopted by the American Dermatological Association. In a few respects, however, the author wheels from the regular track, as, for instance, in considering lichen-planus and lichen-ruber distinct diseases; in this he is in accord with Kaposi and Robinson. Dermatitis herpetiformis, erythrasma, myxedema and other new and recently described affections receive attention. An exception is taken to the name of the first-mentioned, that of Dermatitis "*multiformis*" being considered more appropriate and descriptive. Reference is made also to "Prairie Itch," variously known as "Texas Mange," "Swamp Itch," etc. The author goes to the root of the matter, we think, when he states that his "personal experience has led to the conviction that these terms are loosely applied to a group of cutaneous symptoms of diverse origin;" the cases, as a rule, representing pruritus hiemalis and scabies. The operation of electrolysis for the removal of superfluous hairs is clearly and satisfactorily described. With the suggestion "to operate in succession on contiguous hairs when practicable" our experience is, however, not in accord, as under such circumstances conspicuous scarring almost invariably results. The use of cocaine inunctions or hypodermic injections, for the purpose of rendering the operation less painful, is very properly considered unnecessary and inadvisable. The subject of differential diagnosis is con-

sidered at length, and in the matter of treatment, also, it is fully up to date.

In fact, as already intimated, this second edition of Dr. Hyde's treatise is in reality a new work, and we are pleased to say reflects great credit upon its author. The student or practitioner will find it valuable either as a text-book or as a book of reference. The publisher's part has been equally well done.

CORRESPONDENCE.

Correction.

DR. P. F. VAN HAMEL ROOS, editor of the *Revue Internationale Scientifique et Populaire des Falsifications des Denrées Alimentaires*, thanks for the communication in your esteemed Journal (April 7, No. 14, p. 451), about his experiences with *nickel salts*. He begs to observe, the orthography of his name, as mentioned in your Journal, is not exact, and kindly requests to alter this in the next number of your Journal.

Amsterdam, April 21, 1888.

Correction.

In the article by Dr. Hiram Corson in the REPORTER, May 5, on "Quinine, its Use and Abuse," on page 561, first column, thirteenth line from the bottom, read "ten grains, in doses of one or two grains every hour," instead of "ten grains every hour." The mistake is to be regretted especially because it makes Dr. Corson seem to advocate a practice which he distinctly states is both needless and costly. The firm of chemists referred to as the manufacturers of quinine in 1825, should have been Farr & Kunzi, instead of Farr & Kirnzic.

NOTES AND COMMENTS.

Congenital Absence of the Vagina with Retention of Menstrual Fluid.

Drs. J. S. and A. S. McMurray, of Frankford, Ind., report a case of this kind in the *American Journal of Obstetrics*, March, 1888. The patient, who was 16 years old, came under their care August 2, 1888, with the following history as given by her mother: She is a twin, her mate having died in infancy. She had a mild attack of scarlatina at six years of age, but no sequelæ were recognized. She was of a cheerful disposition, healthy and vigorous, in mind and body, until about sixteen months prior to the above date, when she experienced the symptoms common to the advent of the menstrual function. But as there was no "show," the attempt was considered abortive. A few weeks subsequently the same symptoms supervened, somewhat aggravated. From this time on, these attacks recurred every four weeks with

all the regularity of the well-established menstrual function; each time becoming more painful and lasting a longer time, until about six months before they saw her, when they became continuous and she had lost her health and vigor. During this time, the breasts were well developed, together with all the evidences of maturing womanhood. She was constantly under professional surveillance; her attendants gave her morphine and other anodynes for temporary relief, and emmenagogues without limit, but they availed nothing. Presuming hers to be a case of delayed menstruation, no examination of the genitals was made until this time, when she was taking from *three to five* grains of morphine a day, without obtaining even an hour's respite from pain. She grew worse and worse, and finally came under their care. She was then exceedingly emaciated and anemic, and her weight was about seventy-five pounds. Her face had the peculiar pinched look characteristic of long suffering and the morphine habit. Upon making an examination, they found the hypogastric region prominent, and easily outlined a well-defined globular mass, very similar to the pregnant uterus of five or six months. The pubes were well covered with hair, and the labia majora well developed, though upon being separated they revealed no introitus vaginæ, but only a shallow *cul-de-sac*, skirted with carunculæ myrtiformes. The perineum was distended; the anus pushed forward, "pouting," as in the second stage of labor. On introducing the finger into the rectum, a tumor was discovered pressing the perineum, and feeling to the touch like the œdematous scalp of a child's head approaching the vulva. It was thought that the uterus could be detected through the abdominal parietes, closely hugging the tumor above. This, however, was a deception as subsequent developments plainly showed. The ovaries were not discovered. The bladder was pushed upward and forward, and it was with difficulty that a catheter could be introduced.

Bearing in mind the history, linked with the facts present, they diagnosticated a typical case of congenital absence of the vagina, with retained menstrual fluid. She was put on tonic and aseptic treatment for several days, and on August 8 was operated on in order to establish a vaginal canal. The patient was placed in the lithotomy position, and the bladder being emptied through a catheter, a strong steel staff was passed through the urethra and held in position, steadying the vesico-rectal septum, and subsequently serving for a guide to protect that organ and the blad-

der. The bottom of the interlabial *cul-de-sac* was raised with a tenaculum, and an elliptical section snipped away with scissors, parallel with the lips, one inch in length by half that width. Now, with two fingers of the right hand in the rectum, an exploratory trocar and canula was carefully passed in the direction of the normal vaginal line. When at a depth of two inches, resistance ceased, and the trocar was withdrawn, followed by a small issue of menstrual fluid, confirming the diagnosis. A long probe was passed through the canula which was then withdrawn, leaving the probe in its track, it serving as a guide to direct the advance of the forefinger of the left hand, with which the vaginal track was opened. Through this, there issued a flood of forty-eight ounces of dark, ropy fluid resembling treacle, so tenacious that it could be drawn out in threads a yard long. When the contents were well evacuated, the finger was again introduced, and the opening extended transversely both right and left until it was enlarged to the normal vaginal capacity. On examining the cavity, its walls were as firm as cartilage. Search was made for the uterus, but it was not recognized. The cavity was then thoroughly washed out with a hot solution of bichloride of mercury. A glass plug, as recommended by Sims, one inch in diameter, and three inches long, was then put into the canal. But it would not go as far as necessary, and on searching for the obstruction a stricture of the cavity was manifest, sufficiently close to prevent the introduction of the plug to its full depth. On closer examination, however, this proved to be the *cervix uteri resuming its natural form*, thus showing the uterus and a small portion of the vagina to have been one continuous cavity. The plug was retained in place by a T-bandage. She was put to bed and soon rallied from the anæsthetic. She at once began to complain of severe pains in the pelvis, which were true "after-pains," such as follow labor. She was given a full anodyne, but these pains persisted and did not disappear for nearly a week. Twice a day, for two weeks, the plug was removed, and the cavity thoroughly washed out with the bichloride solution; then once a day, for three weeks.

In a few days she began to build up, and rapidly convalesced. The glass dilator was worn at least twelve of each twenty-four hours, for three weeks after suspending personal surveillance of the case.

After about the tenth day all opiates were suspended; in fact no demands were present for their use, notwithstanding the liberal administration of morphine daily for over

twelve months previous. A troublesome diarrhoea followed, attributable to the withdrawal of the drug, but as digestion improved and the system regained the function of assimilation, no further difficulty of this kind was experienced. Five weeks from the day of the operation, she walked into the authors' office, having come ten miles by rail the same morning. She still wears the plug at night, and will do so for a long time. The canal is as nearly natural as scar tissue, forming over a glass plug, can be, so soon after the operation.

Castration and the Development of the Genital Tract.

Dr. Kehrer, in 1879-80, made a series of experiments to ascertain the effect of castration on the development of the genitals in young animals; the results were published in his *Beiträge zur klinischen und experimentellen Geburtskunde und Gynäkologie*. He castrated rabbits between two and three months of age, and killed them one year later. He found that unilateral castration or spaying caused no arrest of development; on the other hand, when the operation was performed on both sides, the genitals and mammary glands remained stationary, never developing beyond the stage which they had attained when the essential organs were removed. Dr. Kehrer attempted to prove which theory was true—Pflüger's, according to which there existed in the uncastrated female a stimulus to growth through periodical irritation of the ovarian nerves set up by the ripening of follicles which goes on long before puberty; or, on the other hand, the theory that spaying caused a disturbance of the blood supply of the remaining genital organs, through the occlusion of the ovarian arteries. For this purpose he ligatured the ovary and ovarian artery in two series of experiments. He found that neither in unilateral nor in bilateral ligature of the tubes or extremities of the uterine cornua, with separation of the ovarian arteries, was the normal development of the genitals in any way affected. He concluded that the ovarian nerves, or some other and unknown influence in connection with the ovaries, played the most prominent part in stimulating the development of the genital tract.—*British Medical Journal*, March 10, 1888.

For Pityriasis Versicolor.

Ihle recommends the following:

B	Resorcin.....	gr. lxxv-c
	Castor-oil.....	f ʒi ʒ
	Alcohol.....	f ʒiv ʒ
	Balsam of Peru.....	gr. viiiss
M.	ft. liniment.	

Acetophenidine.

M. Gueroguiewsky has employed acetophenidine instead of antipyrin. It is a crystalline gray powder, insipid and inodorous, derived from phenol; it is soluble only in twenty parts of alcohol, and is eliminated by the urine, wherein it can be detected by the red coloration with perchloride of iron. In typhoid fever, tuberculosis, erysipelas and pneumonia, in doses of from two and a half to five grains, he found it to act as an antipyretic in from twenty to forty minutes after injection; the pulse and respiration diminishing in frequency, and sweating being induced. It also relieved pain, but doses of eight or ten grains are required to effect this end, as in migraine, cephalalgia and tabetic pains. It never upset the stomach, nor modified any of the other functions of the body; in this respect it seems to be superior to antipyrin.—*Lancet*, March 24, 1888.

Effects of Moderate Drinking on the Heart and Circulation.

Dr. George Harley sums up the effects upon the heart and circulation which he believes follow the moderate use of alcohol, in the following propositions: 1. Alcohol, when indulged in, even well within the limits of intemperance, has a most prejudicial effect on heart disease. 2. Sudden spurts of muscular exertion act most deleteriously on all forms of organic cardiac affections. 3. Mental excitement is a cause of rupture of atheromatous blood-vessels. 4. A mere extra distension of a stomach by wind may suffice to fatally arrest a diseased heart's action. The knowledge of these facts, he says, has for some years past led him to make it an invariable rule to impress upon all patients laboring under diseases of the circulatory system, who desire to minimize the effects of their complaints and ward off as long as possible the inevitable fatal termination, to pay strict attention to what he calls the following three golden rules: (1) Take exercise, without fatigue; (2) Nutrition, without stimulation; and (3) Amusement, without excitement.—*Lancet*, March 24, 1888.

Death from a Druggist's Blunder.

The N. Y. *Evening Post*, April 11, 1888, says that considerable excitement has been caused at Bellows Falls, Vermont, by the result of the examination of the remainder of the medicine taken by one Wm. Riley, April 5, from the effects of which he died. He called at a drug store for ten grains of quinine, which he mixed with whiskey, and then swallowed two thirds of the mixture.

Examination proves that the supposed quinine was morphine. The authorities have not as yet taken any action.

Proposed Plan of Supplying Infants with Pure Milk.

The Paris correspondent of the *N. Y. Medical Journal*, April 7, 1888, says:

The *Société de Médecine pratique*, while recognizing that mother's milk is the best for children, cannot, however, overlook the fact that an immense majority of babies are now-a-days brought up on cows' milk, and, as they are of the poorer classes, who cannot pay enough to secure pure milk, it begs the city government to take the matter in hand, and to construct and maintain model dairies, as is the practice in the towns of Stuttgart and Hamburg. A call is made upon the patriotism of the French Government to adopt this plan of securing pure milk for the babies, whose numbers are being diminished by thousands every year, and the hope is expressed that the city will undertake the important work of supplying pure milk at a low price for all the poor babies of Paris. It is not a bad idea if it could be carried out without making a job of it, as would be the result in some countries if it was a government affair.

Method of Identifying Criminals.

The anthropometrical method of identifying criminals, originating in Paris, has been adopted in the prison at Joliet, Ill. In addition to the photograph of the prisoner, accurate measurements of his height, the length and width of his head, the length of the left middle and little finger, of the foot, the forearm, the ear, the stretch of the arms, description of scars, color of the eyes, and so on, are recorded; and it is thus possible to identify prisoners assuming false names with far greater ease than was before possible. It is asserted, that, in the two years that the system has been in operation in Paris, 826 habitual criminals arrested under assumed names have been identified. Besides the practical utility of the system, it amasses very valuable statistical data contributing towards the natural history of the criminal classes.—*Science*, March 30, 1888.

New Resident Physicians.

Drs. James H. MacMillan, W. T. Sharpless, M. G. Miller and C. W. Sharples, who passed the requisite examination for Resident Physicians of the Philadelphia Hospital, entered upon their duties May 2. There are at present 1,629 patients in the hospital.

Vaccination in China.

Small-pox is epidemic in Hong-Kong, and during the week ending January 28, eighty-eight persons died from this disease. A law has been passed by the Governor and Council making the practice of infant vaccination compulsory in the colony, the Chinese member of the Council stating that his countrymen were strongly in favor of it. A local newspaper sent us by a correspondent enables us to learn something of Chinese thought upon the subject, the article referred to being based upon a pamphlet written by a Chinaman named Chang. The object of vaccination in China, it seems, is to purify the child of the foetal virus which every child possesses, and which is generated by the passions which gave him birth, and this virus is the attractive cause of small-pox and other ailments. The Chinese anti-vaccinationist evidently accepts this theory, but comments on the absurdity of attempting to let this virus out in two or three pustules. Mr. Chang, however, has a ready reply: The foetal virus congregates about the Gate of Life and the Three Passages. He does not say where these are, but on either arm, between the shoulder and the elbow, are two depressions, the "eddy of purity and cold," and the "lesser estuary," which two communicate by means of veins directly with the Gate of Life. By introducing vaccine, therefore, in the upper part of the arm, it is conveyed by the flowing of the blood along the vein to its goal. For the reason that "blood must be warm before it can flow," (*vide* Chinese text-books) "cold" food must not be given the patient, or rather, to use our popular expression, food which is credited with being "cooling."—*Lancet*, March 24, 1888.

Masculine Attire for Women.

A petition of a somewhat eccentric nature has just been addressed to the Chamber of Deputies by a young French lady. It is nothing less than a demand on behalf of women generally to be allowed to don male attire. The fair petitioner claims that woman will be better at ease and enjoy more freedom in her motions if dressed as a man. She instances the recent calamities in theatres in support of her statement that the loss of life would not have been so appalling had not a great part of the audience worn petticoats. The custom of the fairer portion of mankind wearing male attire is said to have originated in England. In fact, a female society, existing in England, has boldly raised the

standard of revolt. At clubs and meetings its members appear in male costume, which, by the way, they wear with more conviction and pluck than elegance. The statutes of the society call upon its members to lose no opportunity of publicly manifesting their rooted aversion to gowns, skirts and petticoats. "This is the only way," said the president of the society, "lately, 'we shall succeed in overcoming routine, and ridding ourselves of the ugly, heavy, uncomfortable and costly dress we have been condemned to wear for centuries.'" To this question, however, there is another side, apart from the comical aspect, and were coquetry not in the van to vindicate its rights, with the majority of French women, who would not fail to stand by it, we might predict to the "young French citizeness" and reformer of dress, that routine itself will constitute the necessary damper.

The Use of Acidified Corrosive Sublimate as an Antiseptic.

Some very interesting experiments of great practical importance have recently been made by E. Laplace (*Deutsche medicinische Wochenschrift*, 1887, No. 40, p. 866-7) in the Hygienic Institute of Berlin, on the antiseptic action of corrosive sublimate when used in acid solution. It has long been known that the efficiency of bichloride of mercury is much reduced when it is brought in contact with albuminous substances, owing to the formation of insoluble compounds; thus when applied to animal tissues, the mercury becomes mordanted, as it were, on the surfaces with which it first comes in contact, the sphere of its activity being thus greatly diminished. Laplace finds that five cubic centimetres of blood serum is sufficient to precipitate the mercury from five cubic centimetres of the bichloride solution (1-1000). The formation of this precipitate of albuminate of mercury can be prevented by adding dilute hydrochloric acid (5-1000) to the bichloride solution (1-1000), whereby the antiseptic power of the latter is greatly increased. Similar results were obtained by the addition of tartaric acid. The solution recommended for use consists of 1 part sublimate, 5 parts tartaric acid, and 1000 parts of distilled water. The bandages, gauze, etc., on the other hand, are soaked for two hours in a stronger solution; namely, sublimate 5 parts, tartaric acid 20 parts, distilled water 1000 parts, after which they are wrung out and dried.—*British Medical Journal*, Jan. 21, 1888.

Mastoid Periostitis from Injury to the Auricle.

Dr. Thomas Barr, surgeon to the Glasgow Ear Hospital, reports, among other traumatic affections of the ear, a case of injury to the auricle, exciting mastoid periostitis. The patient was a boy, who stated that three weeks previously a man caught hold of his ears, lifted him off the ground, and suspended him in this way for a few seconds. The boy alleged that there was no pain at the time. A few days afterwards, however, pain and swelling commenced around the auricle, which was treated by hot fomentations. On admission he was suffering from intense pain over the right mastoid region and side of the head. The pain was so severe, that he had not slept for two nights. The auricle was jutting from the side of the head, and the swelling and the oedema extended from the mastoid region very markedly over the temple, right side of forehead, lower eyelid, and front of ear. The swelling over the forehead pitted deeply under pressure with the tips of the fingers. There was, however, very little redness anywhere. The internal ear was normal. There had been no rigors, but the temperature was 101° . Although there was no evidence of the existence of pus, it was resolved to cut into the tissues forming the seat of greatest pain. Chloroform was used, and an incision two inches in length was made through the soft tissues and periosteum, to the bone. Only a drop or two of pus escaped, apparently from beneath the periosteum. The effects of this incision were most satisfactory. All the unpleasant symptoms rapidly abated, and in the course of a fortnight the boy was at work again, and the incision wound almost healed.—*Popular Science News*, March, 1888.

New Eye and Ear Hospital.

Articles of incorporation have been secured for the New Amsterdam Eye and Ear Hospital of New York. Dr. Pooley, who was for fifteen years the first assistant surgeon of the New York Ophthalmic and Aural Institute founded by Dr. Knapp, is the executive surgeon in charge of the new hospital. It is expected to open in a short time. The hospital is to be supported entirely by voluntary contributions.—*Evening Post*, May 4, 1888.

Western Pennsylvania Medical College.

The annual commencement of the Western Pennsylvania Medical College was held on March 24, and thirty-four men were graduated as physicians. A collation was served to

the graduating class in the evening by the Faculty and alumni. This commencement closes the second successful year of this college.

University of Pennsylvania.

The one hundred and fourteenth annual commencement of the Department of Medicine and Dentistry of the University of Pennsylvania took place May 2, at the Academy of Music. Prayer was offered by Bishop Whitaker, after which Provost Pepper conferred the degree of Doctor of Medicine on 114 graduates, and the degree of Doctor of Dentistry on 56 graduates. This was followed by the valedictory address, delivered by Dr. John Ashhurst, Jr., Professor of Clinical Surgery. A portrait of Professor R. A. F. Penrose was presented to the Board of Trustees by Dr. N. H. Hall, on behalf of the graduating class. Dr. James H. Hutchinson responded for the trustees.

The following prizes were awarded:

The Alumni Prize of \$50, to the graduate who attains the highest general average in examination, to William T. Sharpless, of West Chester, Pa.

Medical News Prize of \$100, for the best thesis, divided between John L. Hatch, of Rochester, N. Y., and Seneca Egbert, of Franklin, Pa.; distinguished mention to Adolfo Ferrer Leon, of Tabasco, Mexico.

Morbid Anatomy Prize of a Zentmayer's histological microscope, for best thesis on any subject connected with pathology, to Casper Wistar Sharples, of Eugene City, Oregon.

Demonstrators' Prize, \$30, by Dr. John B. Deaver, Demonstrator of Anatomy, for best record of anomalies found in the dissecting room, to John T. Green, of Easton, Pa.

The following prizes were awarded by Dr. J. William White, Demonstrator of Surgery:

First Year Prizes—Proficiency in bandaging: First, Edward Strayer, a copy of "Agnew's Surgery;" second, Wesley A. Anders, a copy of "Ashhurst's Surgery." Honorable mention was made of S. P. Eagleton, John P. Frishmuth, Edward Kerr, Thomas P. Tyson, J. D. Webster.

Third Year Prizes — For proficiency in bandaging and in operative surgery: First, "Agnew's Surgery," to Frank P. Lenahan; second, White's pocket case of surgical instruments, to Charles Walter. Honorable mention of John T. Green, Frank N. Yeager, W. T. Sharpless, A. Livingston Stavelly, Shepard Voorhees, Robert G. Le Conte, C. W. Sharples, Frank H. Harding.

NEWS.

—Dr. Charles McBurney has been appointed visiting surgeon to Roosevelt Hospital, New York, in place of Dr. Sands, who has resigned.

—It is announced that Dr. Frank Woodbury has retired from the management of the *Philadelphia Medical Times*, which will hereafter be conducted by Dr. W. F. Waugh.

—Dr. Charles E. Simmons has made a claim upon the Tilden estate of \$143,350 for medical attendance upon the late Samuel J. Tilden, from 1879 up to the time of his death, a period covering nearly eight years.

—The Cincinnati *Lancet-Clinic* is publishing a daily edition during the session of the American Medical Association, in Cincinnati.

—Dr. Howard A. Kelly and Dr. Barton Cooke Hirst have been elected Associate Professors of Obstetrics in the Medical Department of the University of Pennsylvania. They will jointly occupy the chair made vacant by Prof. Penrose's resignation.

—The State Convention of Homoeopaths in Kansas City passed a resolution requesting Governor Moorehouse to remove from the State Board of Health Mr. George M. Cox, of Springfield, Mo., who achieved some notoriety some time ago by attacking a woman in a hack and throwing vitriol in her face.

—All the druggists of Davenport, Iowa, have united in giving formal notice that after April 30, they will not sell or dispense any alcoholic liquor of any kind for any purpose whatever. They have been advised that the conditions of the prohibitory law passed by the last General Assembly are such that business cannot be done without violating it. There are, however, some two hundred saloons still openly doing business in Davenport, besides some wholesale liquor houses.

—The Medico-Legal Society of New York has decided to hold an International Congress of Medical Jurisprudence, at which representatives from all countries will be invited to attend and contribute papers. The Congress will hold a session of four days some time next year. Members of the Medico-Legal Society will entertain as guests all foreign visitors, and arrangements will be made for reduced rates of ocean and railway travel for those who attend from a distance.

The Chairman of the Subcommittee, Mr. Moritz Ellinger, is the Corresponding Secretary of the Medico-Legal Society.

HUMOR.

MRS. SOCIETY—"What a lovely baby that is we just passed." Mrs. Fashion—"Yes; it is mine." "Indeed!" "Oh, I'm sure of it; I recognized the nurse."—*Observer*.

SURGEON'S WIFE—"How is the walking out to-day, my dear?" Physician—"Beautiful, beautiful, the pavements are full of banana skins!" "Ha! ha! beautiful," echoes the reporter on the hunt for items.

"MA, DE FIZIOLOGY SAY YER dat de human body am imposed of free-fourth watah!" "Waal, yo' bettah mosey off to school, an' git outen dat hot sun, ur fust ting yo' know yo' be vaporatin'."—*Harper's Bazar*.

MISS CLARA—"Oh, Ethel, I had my ears pierced to-day!" Miss Ethel—"Weren't you dreadfully frightened?" Miss Clara—"A little at first, but I kept saying 'solitaire,' 'solitaire,' 'solitaire,' to myself, and before I knew it it was all over."

"ONLY THINK," exclaimed Fenderson, reading of the devastations of the locusts at the West, "last summer they ate up every green thing." "What a fortunate escape!" said Fogg; "you were thinking of going out that way last spring, I believe."

JUDGE TO A PRISONER—"Are you married?" Prisoner—"Yes." Judge—"To whom?" Prisoner—"To a woman." Judge—"Of course; that goes without saying." Prisoner—"Oh, no, your honor; for there's my sister; she is married to a man!"

CURIOUS REQUEST FOR MEDICAL SERVICES.—A subscriber to the REPORTER sends us the following request from a young colored man who wished to have his chest examined:

"I acquire your physitiancy to examine my personal, and oblige.

Respectfully,

* * * *

AN IMPERTINENT LAWYER was arguing a case involving manorial law before Lord Mansfield. Said he, "My Lord, I happen to know a good deal about this subject, for I have two little manors myself." "Yes," interposed his lordship, "I have frequently noticed that."—*American Druggist*.

STUDYING THE WEATHER.—"Mamma," said a pretty young thing in her new spring street costume, "have you the morning paper?" "No, Clara; your papa took it down town with him. There is yesterday's morning paper on the table." "Oh, that will do just as well. I only want to look at the weather probabilities."—*Puck*.

OBITUARY.

ISAAC PURSELL, M. D.

Dr. Isaac Pursell was born near Easton, Pa., September 19, 1823. When a child his parents moved to Phillipsburg, N. J., or rather to a farm near there. He studied medicine with Dr. Wilson, of Bethlehem, Pa., and was graduated from the University of Pennsylvania. He first began the practice of medicine at Rushtown, Pa., near Danville, where he married Miss Delia, daughter of Colonel Scott. Shortly after he removed to Berrysburg, Pa., thence to Shamokin, in 1858, and in 1861 to Danville, where he remained until the date of his death. He became a member of the Pennsylvania State Medical Society in 1874, and later of the American Medical Association, to both of which associations he was warmly attached, and the annual gatherings of which, until within two or three years of his death, he greatly delighted to attend.

The writer of this sketch became a student in Dr. Pursell's office, at Berrysburg, and has been in close correspondence with him ever since. He was a careful and conscientious practitioner of medicine, one who carried good cheer and sunshine wherever he went, and his professional visits were a benefit to his patients. He enjoyed a large general practice, which he kept up until a short time before his death. He was the soul of honor professionally, was modest and unassuming in his manners, never paraded his professional qualifications, and heartily detested shams of all kinds, whether in medicine, politics or religion. He was a consistent Christian, and an earnest and pronounced advocate of temperance. He died at his home in Danville, March 27, 1888, of cerebral apoplexy, after a few hours illness.

J. F. K.

J. FORD PRIOLEAU, M.D.

Dr. J. Ford Prioleau, of Charleston, S. C., died at Beaufort, April 11, at the age of 62 years. He was graduated from the Medical College of the State of South Carolina in 1847, and in 1871 he became professor of obstetrics in the same institution. In 1881 he was made Dean of the college, and held that position until the time of his death.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 22, 1888, to April 28, 1888:

Lieutenant-Colonel Jos. C. Bailey, Assistant Medical Purveyor, granted leave of absence for twenty days on surgeon's certificate of disability, with per-

mission to apply for an extension. S. O. 92, A. G. O., April 21, 1888.

Lieutenant Colonel Jos. C. Bailey, Assistant Medical Purveyor, will transfer the public funds, for which he is responsible, and the charge of the medical purveying department in New York City, temporarily, to Capt. Henry Johnson, Medical Storekeeper. S. O. 92, A. G. O., April 21, 1888.

Par. 13, S. O. 89, A. G. O., April 18, is revoked by par. 1. S. O. 93, A. G. O., April 23, and Major Geo. M. Sternberg, Surgeon, U. S. Army, is directed to proceed to the Island of Cuba for the purpose named in the letter of the President addressed to the Secretary of War on the 17th inst.; upon the completion of this duty will return to his proper station, and submit his report to the President on or before June 25, 1888.

Major R. S. Vickery, Surgeon, granted leave of absence for four months, with permission to apply for an extension of two months, and to go beyond sea. S. O. 95, A. G. O., April 25, 1888.

By direction of the President, Surgeon Remus C. Persons, U. S. Navy, is assigned, temporarily, to the charge of the Army and Navy General Hospital, Hot Springs, Ark., during the absence, on leave of Major R. S. Vickery, Surgeon U. S. Army, Surgeon in charge. S. O. 96, A. G. O., April 26, 1888.

First Lieutenant Leonard Wood, Assistant Surgeon, granted one month's leave of absence, with permission to apply for an extension of two months. S. O. 41, Dept. Ariz., April 18, 1888.

First Lieutenant L. G. Anderson, Assistant Surgeon, granted one month's leave of absence from June 1, 1888. Resignation accepted by the President, to take effect July 1, 1888. S. O. 92, A. G. O., April 21, 1888.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 29, 1888 to May 5, 1888:

Capt. A. A. De Lofre, Assistant Surgeon, granted leave of absence for six months on surgeon's certificate of disability, with permission to go beyond sea. S. O. 99, A. G. O., April 30, 1888.

First Lieutenant Guy L. Edie, Assistant Surgeon, now under orders to report for duty to the commanding officer, Fort Douglas, U. T.; will accompany the 8th Cavalry from Dept. of Texas to Dept. Dakota, and upon completion of this duty will proceed to Fort Douglas. S. O. 99, A. G. O., April 30, 1888.

First Lieutenant Wm. D. McCaw, Assistant Surgeon, relieved from duty at Fort Leavenworth, Kan., and ordered for duty at Fort Crawford, Col. S. O. 48, Dept. Missouri, May 1, 1888.

First Lieutenant Ogden Rafterly, Assistant Surgeon (recently appointed), ordered for duty at Fort Clark, Tex.

Capt. John V. Lauderdale, Assistant Surgeon, ordered from Fort Clark, Tex., to Fort Davis, Tex. S. O. 98, A. G. O., April 28, 1888.

Changes in the Medical Corps of the Navy for the week ending May 5, 1888:

Medical Director W. T. Hord and Surgeon T. Woolverton, ordered as delegates to represent the Medical Department of the Navy at the meeting of the American Medical Association, May 8, at Cincinnati, Ohio.

Surgeon Geo. P. Bradley, ordered to Navy Yard, Brooklyn, N. Y., without delay.